	9. Birth	Arundel  Inplace (State or Foreign untry)  MD  10d. Inside City Limits  1 □ Yes 2 ☑ No
Apr.  8. Date of Birth (Month, Day, Y Nov. 3,	2, 2005  4c. County of Death Anne (ear) 1922  9. Birth Co	Arundel  Applace (State or Foreign untry)  MD  10d. Inside City Limits  1 □ Yes 2 ☑ No
8. Date of Birth (Month, Day, Y NOV. 3,	Anne (ear) 9. Birth Con 1922  g. Citizen of What Co	Arundel  Inplace (State or Foreign untry)  MD  10d. Inside City Limits  1 □ Yes 2 ☑ No
Nov. 3,	9. Birth Con 1922	nplace (State or Foreign untry)  MD  10d. Inside City Limits  1 □ Yes 2 ☑ No
Nov. 3,	1922 Coi	MD  10d. Inside City Limits 1 ☐ Yes 2 ☑ No
10g	g. Citizen of What Co	10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	USA	1 ☐ Yes 2 🙀 No
	USA	
	USA	untry?
Specify Yes or No- to Rican, etc.)		
Specify Yes or No- to Rican, etc.)		
	Black, White	
	Specify:	White
16	Sh Kind of Business/	Industry
orking	D. Killa di Basillessa	industry
	AVIS	
me (First, Middle, Ma		
Cheelsman	ì	
		Zip Code)
r. 7.		
2005	Baltimore,	MD
P.A. Sever Hwy, Sever	na Park F na Park,	uneral Home MD 21146
c or respiratory arres	it,	Approximate Interval Between
		Onset and Death Weeks
		1.1.1.1
		weeks
	23d. Date of del	
	Month	Day Year
10		
		o the cause of death?  robably 4 Unknown
I ZA Y OS	2 NO 3 F	Obably 4 Donkhown
24a. Was an autopsy	prior to	utopsy findings available completion of cause of
1 Yes 2	No 1 ☐ Yes	2 🗆 No
		cify)
		ural Route Number,
City of Town,	State)	
ce, and due to the cau curred at the time, dat	use(s) and manner as te and place, and due	s stated. e to the cause(s)
		h, Day, Year)
	712103	
annapoli.	, MD	
	Cheelsman  Cheelsman  Tural Route Number, of Arnold, ME  Date 7, 2005  P.A. Sever  Hwy, Sever  ac or respiratory arres  23e. Did toba  1 12 Yes  24a. Was an autopsy perform 1   Yes   21  28d. Describe how  28f. Location (Stre. City or Town,  Ce, and due to the cac  courred at the time, dain  29	AVIS  The (First, Middle, Maiden Sumame)  Cheelsman  Bural Route Number, City or Town, State, 2  Arnold, MD 21012  Date or 7, 2005  P.A. Severna Park F  Hwy, Severna Park, 1  ac or respiratory arrest,  23d. Date of dei Month  23e. Did tobacco use contribute to death?  1 Yes 2 No 3 Priving to death?  1 Yes 2 No 1 Yes  Path (Check only one)  Home 5 Residence 6 Other (Speel 28d. Describe how injury occurred)  28f. Location (Street and Number or Richty or Town, State)  29d. Date signed (Monthy Course)  29d. Date signed (Monthy Course)  29d. Date signed (Monthy Course)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Year Larry Weigle 10, 2005 April 7:52 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Cumberland Memorial Hospital Cumber land Allegany If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** Days 1□**X**M 2□ F 727-09-9184 73 Yrs. Director Jun 8. WV Usual Residence of Decedent the Maryland 10b. County Mineral 10c. City, Town or Location 10d. Inside City Limits or 28a-f show ed other than "natural", or items 23a or 28a-f showers. The Medical Exercises must be notified at Ridgeley Completed by Funeral Director 1 ☐ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with Rt 3 Box 4 26753 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ ☐ No If Yes, Give Year or Dates: 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 → No 3 ☐ Widowed 4 ☐ Divorced Specify: white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Pages 1 and 2 should be filled within ment of Health and Mental Hygiene. ant: if item 27 is marked other then ' ury or other traumatic evant. Its Me Elementary/Secondary (0-12) College (1-4or 5+) Manager Suburban Propane 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Charles Weigle Emma Weigle 2 19a Informant's Name/Relationship (Type, Print) Rebecca Weigle 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) wife Rt 3 Box 4 Ridgeley WV 26753 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages Department of Important: if it any injury or o Snyder's Chapel Cemetery 4/13/2005 \* 4 ☐ Donation 5 ☐ Other (Specify) Hedgesville WV 21. Signature of Funeral Service Licens 22. Name and Address of Facility Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 234. Part 1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Encephalopath Anoxic disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner physemo Sequentially list conditions. Tary leading to in reclate cause. Enter Underlying Cause (Disease or injury Examiner The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4☐Pregnant at time of death 5 Other (specify) P.O. 9☐ Unknown 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed Alcahol 3 Probably 4 □Unknown 1 No Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate 1 Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28b. Time of 28d. Describe how injury occurred

Division of Vital Records, Hospital or Attanding Physician: After thi death. Director: 24 hours a vithin 2 the

28a. Date of Injury (Month, Day Year) Certification: 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Momicide 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

D54946

April (2, 2005

State Registrar

10

Bayd Sprenkle M.D.

31. Date liled (Month, Day, Year)

32. R Day, Year) APR 2 0 2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

600 Memorial Ave. Cumberland, Maryland 21502

		1 - For State Registrar	State of Ma	aryland /	Departme Certifica			d Mental Hy	giene Reg. No	DOOR	13503
Dharaini		1. Decedent's Name (First, Middle, L	ast)					2. Date of Do		y Year	3. Time of Death
Physicia /Medic		PATRICIA ANN						April	Day	2005	- 1900 M
Examin	er	4a. Facility Name (If not institution, gi			4b. C	ity, Town, o	r Location of De	eath		County of Dea	
			nal Medical Sex 7. Ac	Cent	ojethedou i littin	Sali der 1 Year	Stury If Under 24 h	drs 0 Data of B		Nicon	10
Funeral Director			1 M 2 M F	65	Yrs. Montl			lin. 8. Date of Bi (Month, D OCT • 28	, Year) , 19:	39 NE	rthplace (State or Foreign Country) LW.,YORK
ited with the modern state open with the margand that tygiene ad other than "natural", or items 23a or 28a-f show event, the Medical Examinations to institutional at		10a. State 10b. County		10c. City, To	wn or Location						10d. Inside City Limits
Department of Health and Mental Hygiene. Important: If itam 27 is markad othar than "natural", or Itams 23a or 28a-f show any injury or othar traumatic event, the Medical Examiner must be multiped at 2008.	ţ	MD WICOMIC	CO	SAL:	ISBURY						1 XYes 2 ☐ No
r 28a tricili	Funeral Director	10e. Street and Number			10f.	Zip Code			10g. Cit	izen of What C	ountry?
23a c	a D	5273 GREEN HII	L CIRCLE			21856	Ó		U	.S.	
ams	ner	11. Marital Status	12. Was Decedent Armed Forces?		13. Was De If Yes, s	cedent of H	lispanic Origin? an, Mexican, Pu	(Specify Yes or Nierto Rican, etc.)	0-	14. Race - Am Black, Wh	
i o	by Fu	1 Never Married 2 Married	1 Yes 2X	No		s 2XNo	Specify:			Specify:	
ural al Ez		3 Widowed 4 Divorced	Year or Dates:	1.46	December 1	110	-1		1 100 10		WHITE
"nat	Completed	15. Decedent's I (Specify only highest g		16	a. Decedent's U (Give kind of life DO NO	work done Work retired	ation during most of i d)	working	16b. K	ind of Busines:	s/Industry
than the M	E G	Elementary/Secondary (0-12)	College (1-4or :	5+)	TEACH		-)		1	EDUCATI	ON
nt, tr	e Co	17. Father's Name (First, Middle, Las	t)		TIMOI		18. Mother's f	Name (First, Middle			OIT
90 0	8	JOHN P. DELEHA						RET ANKEN			
mati	ဥ	19a. Informant's Name/Relationship	(Type, Print)	15	9b. Mailing Addr	ess (Street	a <i>nd N</i> um <i>ber</i> or	Rural Route Numb	er. City o	or Town, State.	Zin Code)
trau		HENRY YURKONIS						CLE, SALI			
othar		20a. Method of Disposition			of Disposition (i			Date		ocation - City o	
y or		1 X Burial 2 ☐ Cremation 3			MICHAELS			-15-05	HOI	LLIDAYS	BURG, PA
injur Pe		21. Signature of Puneral Service Lice			22. Name	M and Addre		SHORT FU			
Important: It any injury o QDC8.		Hima 2	m Sla	1				MILTON,			CES
		23a. Part1. Enter the disease, or con	nplications that caused	the death. D						9900	Approximate
		shock, or heart failure. List onli Immediate Cause (Final		no. STATI	P	210	BEAT	ic CA	121	ER	Interval Between Onset and Death
ician dical		disease or condition resulting in death)	a	a consequence		MINC	acen i	ic Cr	714		5 MONTH.
niner		#2000000000000000000000000000000000000	200 10 (0. 00	u consequenc	0 01/.						
	ē	Sequentially list conditions, if any, leading to immediate	Due to (or as	a consequenc	e of):						
ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	C								
rial-tr		resulting in death) Last	Due to (or as	a consequenc	e of):						
the burial-transit	cal		d								
should be detached for use as the	Med	IF FEMALE:			-				4.5		
r use	Physician/Med	23b. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth		th 3⊡Ectopia	c pregnancy	,		- 1	23d. Date of de	•
of be	SICI	in the past 12 months? 1 ☐ Yes 2 🔀 No	4□Pregnant at 9□Unknown		5 Other					Month	Day Year
tach	h.	9 🗌 Unknown									
pe de	by	Part II. Other significant conditions	contributing to death b	ut not resulting	in the underlyin	g cause giv	en in Part I.				o the cause of death?
P N	ed							- 10	Yes 2	<b>23.</b> No 3 □ P	robably 4 Unknown
2 sh	Completed							24a. Was		24b. Were a	utopsy findings available completion of cause of
oage	ШО							perf	ormed?	death?	
In by the funeral director, page 2 should	Be	25. Was case referred to medical					26. Place of [	Death (Check only			
direc	To	examiner? 1 ☐ Yes 2 🔀 No	Hospital: 1 X Inpatie	ent 2 ER/	Outpatient 3	DOA Oth	er: 4 🗌 Nursin	g Home 5 🗆 Res	idence	6 ☐Other (Spe	ecify)
neral		27. Manner of Death 1   Natural 5 □ Pending	28a. Date of Inju (Month, Da	ry Year) 28b	. Time of Injury	28c. Injun Wor	y at k?	28d. Describe	how injur	y occurred	
he fu	atle	2 Accident investigati	on		M		Yes 2 □ No				
by t	Certification:	3 Suicide 6 Could not determine		ury - At home, c. (Specify)	farm, street, fac	tory, office		28f. Location ( City or To	Street an	d Number or F	iural Route Number,
ed in	Cer										
completely filled in by the fu		29a. Certifier 1 Certifying F	hysician: To the best miner: On the basis o	of my knowled	ge, death occurr	ed at the tin	ne, date and pla	ace, and due to the	cause(s)	and manner a	s stated.
plete	ledical	one)	and manner st	ated.				at the thire,			` '
COL	Σ	29b. Signature and title of certifier	M.	7		29c. Licens	e number	962		te signed (Mon	
		P	102	por?	1.0		4- <	6	+41	RIL	10,2005
in		30. Name and address of person who	completed cause of c	leath (Item 23a	(Type, Print)	100€	CARROLL	ST. SALIST	4114	MITED	MT 7102
10		M. SHIRAZI			MLAK	EG10	INUT	, , , , , , , , , , , , , , , , , , , ,	- 66	NO TORY	0 21001
0.1	ite	31. Date filed (Month, Day, Year)	32 Registr	ar's Signature	1	-					

- /		•	1 - For State Registrar	State	of Marylan	•	artmen rtificate			ınd M	ental Hygi	ene g. No.	005	135	504
	Physici	an	1. Decedent's Name (First, Middle		1						2. Date of Death April 1	2 <sup>Day</sup> 20	O S <sup>Year</sup>	3. Time o	f Death AM M
	/Medic	al	Bernard Aloy				4h Cihi	Tourn or	Location o	d Dooth	April 1		nty of Death		AM W
-	Examin	er	4a. Facility Name (If not institution 102 Castleto		umberj			imon		o Oballi			Baltim		
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under Months		If Under a	24 Hrs. Min.	8. Date of Birth (Month, Day,		9. Birth	place (State	or Foreign
	Director		220-20-9126	1 X M 2 □ F	77	Yrs.	Months	Days	Hours	tviii i,	July 6,			land_	
	pu au		Usuel Residence of Decedent  10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d. Inside C	ity Limits
	daryla f eho	٥	MD Balti	more		Timon								1 🗆 Yes	2 <b>X</b> No
	7 28e	rect	10e. Street and Number				10f. Zip	Code			10	g. Citizen	of What Cou	ntry?	
	th with	aD	102 Castletown	n Road				2	21093			U	SA		
	ems erm	Funeral Director	11. Marital Status	Armed F		.S. 13.	Was Deced	lent of Hi	spanic Orig	gin? (Spe , Puerto	ecify Yes or No- Rican, etc.)		Race - Amer Black, White		
36	rs afte	by Fi	1 ☐ Never Married 2 🕅 Marri 3 ☐ Widowed 4 ☐ Divorced	ied 1 XYes If Yes, G Year or I	2 No ive Dates: 1 / E	16	1□Yes :	2⊠ No	Specify:			Spe	cify: W	hite	
Maryland 21215-0036	within 72 hours after death with the Maryland ene. than "natural", or Items 23e or 28e-f ehow the Medical Exaction must be routlind at		15. Deceden	t's Education	7.7	16a, Dece	dent's Usua	il Occupa	ation		1	6b. Kind o	f Business/li	ndustry	
215	hin 73	ple	(Specify only highe. Elementary/Secondary (0-12)		) (1-4or 5+)	(Give	kind of wor DO NOT us	rk done d se retired	luring mosi )	of work	ng				
2	filed wil Hygien other th	Completed	12	4			acco	ıtan			45° - 14° - 14° - 1		nanci	a1	
and	ould be fil Mental H varked oth	Be	17. Father's Name (First, Middle, William George								(First, Middle, N				
2	should be filed within 72 hours after death with the Marylan nd Mental Hygiene. If marked other than "natural", or Items 23s or 28e-f ehow marke other than "natural", or Items 23s or 28e-f ehow marke event, Its Medical Exaction marker coulding a	은	19a. Informant's Name/Relations			19b. Mailir	ng Address	(Street a			Theresa  Moute Number,			p Code)	
	od 2 shoulth and 27 is my		Ann Appel/spo								imonium,		21093		
altimore,	permit. Pages 1 and 2 should Department of Health and Men Importent: If Item 27 is marke eny injury or other traumatic 8DES.		20a. Method of Disposition  1  Burial 2  Cremation  4  XDonation 5  Other (S		1 ~	Place of Dispo semetery, crei	osition (Nam matory or o	ne of ther place	e)	C	Date 2	20c. Locatio	on - City or T	own, State	
Baltii	permit. Pag Department Importent: I eny injury o		21. Signature of Funeral Service		irector	r S	2. Name an tate 1 altimo	d Addres	ony B	y 9ard 2120	1 <sup>655</sup> W.	Balti	imore	Street	
1760,	Physician and wascian and physician and physician transit be pural-transit	Ical Examiner	shock, or heart failure. L'ist immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that infliated events resulting in death) Last	a. Due to	o (or as a conseq o (or as a conseq o (or as a conseq o (or as a conseq	Arte uence of):	erstur en c	( iv	i fac	rian	i			Interval Be Onset and ID may 20 4	CAVS
.O. Box 68	Physician: The law requires that the death certificate be executed ribs certificate has been signed by the attending physician and rall director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live	utcome of pregna birth 2 Peta gnant at time of d nown	Ideath 3	∃Ectopic pr □ Other (sp					23d.	Date of deliment	very Day	Year
<u>α</u>	quires that the signed by the detaction of the detaction	by	Part II. Other significant conditi	ons contributing to	death but not res	ulting in the u	nderlying c	ause give	en in Part I			oacco use d		the cause of	
Vital Records,	Physician: The law require this certificate has been sis al director, page 2 should b	Completed									24a. Was ar autops perform 1 Yes 2	у .	4b. Were au prior to death? 1 \( \sum \) Yes	opsy findings ompletion of 2 No	s available cause of
/ita	clan: ertific ector.	Be	25. Was case referred to medical examiner?	Hospital:				Oth			h (Check only on				
of	Physic this cral dire	£.	1 ☐ Yes 2 ☑ No  27. Manner of Death	11		ER/Outpatier 28b. Time o					me 5 Peside 28d. Describe ho			rify)	
o	ding th: After	tlon	1 Natural 5 Pendir 2 Accident investi	9	e of Injury onth, Day Year)	Injury	м	8c, Injury Work 1 □ 1	k? Yes 2 □	1		1.,			
Division	if or Attending after death. I Director: After d in by the fune	Certification:	3 Suicide 6 Could 4 Homicide determ	not be 28e. Plac	ce of Injury - At hi ding, etc. (Specil	ome, farm, st fy)	reet, factory	, office		1	28f. Location (St. City or Town		umber or Ru	rai Route Nu	mber,
	To the Hospital or Attending is within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	Medical C		ng Physician: To the Examiner: On the and ma											(s)
	To the within 2 To the comple	ğ	29b. Signature and fills of certifie	r					e number	,	2	9d. Date si	gned (Month	, Day, Year)	
7			July 1	MO				D5?	3446	2		4pri	1 15	,200:	5
			30 Name and addless of person		/		Print)			Bai	ltima	ie,	ma	2.	
250	Sta Regist		31. Date filed (Month, Day, Year APR 2 1	2005	Registrar's Signa	ature	E					,			

			1 - For State Registrar	State of M	aryland /	•	rtment tificate					jiene 10g. No.2	00	5	135	05
	Physicia /Medic Examin	al	Decedent's Name (First, Middle, La     Walter C. Bass     4a. Facility Name (If not institution, give				4b. City,	Town, or	Location of		2. Date of Dea Month	Day 21	Yea 200	25	0 100	Death A M
	Funeral Director	E1	Saint Agnes 5. Social Security Number 6.5	Healthe		birthday) Yrs.	If Under Months		If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day Dec. 4,	Year) 1913	N/A 9. B V		e (State or	Foreign
	9	ector	Usual Residence of Decedent  10a. State 10b. County  MD N/  10e. Street and Number	A	10c. City, T	own or Lo		timo	re				on of What	10d.	Inside City	
(O	permit. Pages 1 and 2 should be lied within 72 hours arier death with the maryland Department of Health and Mental Hygiane. Department of Health and Mental Hygiane. Important: If them 27 la marked other than "natural", or Itema 23a or 28a-f show any injury or other traumatic event, the Modical Examiner must be notified at ance.	Completed by Funeral Director	2900 Benson Aven  11. Marital Status  1 Never Married 2 Married	12. Was Decedent Armed Forces? 1 \( \text{Yes} \) 2\( \text{Yes} \)	•	1	Was Deced	212 lent of Hi	spanic Ori n, Mexican		cify Yes or No- Rican, etc.)	Uni	Lted : Race - Ar Black, W	Stat merican hite, etc.	es Indian,	
21215-0036	inin /z nours a e. an "natural", o iMedical Exan	npleted by	3 Widowed 4 Divorced  15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	If Yes, Give Year or Dates: ducation ade completed)  College (1-4or		16a. Dece (Give life.	dent's Usua kind of wor DO NOT us	Il Occupa rk done d se retired	turing mos )			16b. Kind	pecify:  I of Busine:  Land	ss/Indus Tran	•	
Maryland 21	ould be filled will Mental Hygian arked other th atic event, the	To Be Con	10 17. Father's Name (First, Middle, Last James A. Bass	)		S	uperv	isor	18. Mothe		(First, Middle, ae Tay1	Maiden Si	nority umame)	У		
ore, Man	as 1 and 2 sho of Health and I item 27 Is ma r other trauma		19a. Informant's Name/Relationship  James C. Bass  20a. Method of Disposition  1路Burial 2□Cremation 3 ☐	Son	20b. Plac	1009	•	sley	Aven	ue,	Baltimo	re, N		223		
Baltimore,	permit. Page Department of Important: If any injury of once.	(	4 Sonation 5 Other (Speci	y)	Loud	- 2		d Addre	s of Facili	y Amb	2005 rose Fu Rd., A	neral		e, I	nc.	
ı	nysician /Medical	<i>y</i> 1	23a. Part1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	aMyo	d the death.	Do not en		e of dyin	g, such as					Ap	oproximate terval Betw nset and De luce	veen leath
1760,	atie be executed with physician and the burial-transit	lical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying. Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as	s a consequer	nce of):									-	
.O. Box 68	death certific e attending p id for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a	2 Fetal de	eath 3	Ectopic pr					23	d. Date of Month	delivery Da	ıy Yı	'ear
ords, P.	The law requires that the ste has been signed by th page 2 should be detache	by	Part II. Other significant conditions	contributing to death	but not resultii	ng in the u	inderlying c	ause giv	en in Part I	l.			e contribute			
		Completed									1 ☐ Yes	rmed? 2 <b>K</b> No	24b. Were prior death 1 🔲 Y	to compl	findings a letion of ca	vailable use of
ot	ding Phye	Certification; To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending investigate  3 Suicide 6 Could not	20	ury 28 ay Year)	8b. Time o	M	28c. Injur Wor 1 🔲	er: 4□Nu	ursing Hor 2	me 5 Resident Residen	dence 6	occurred		loute Alumb	hor
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•	To the Hospital of within 24 hours af To the Funeral D completely filled in	Medical	(Check only 2 Medical Example)  29b. Signature and title of certifier	miner: On the basis and manner s		n and/or in		c. Licens	pinion, dea				signed (Mo	onth, Da		
	1		30. Name and address of person who Kristine Dett	off 901	) S. Ca	too	Avan	ve.			- , MAI			225		
:-	St Regist	ate rar	31. Date filed (Month, Day, Year)	32. Regis	tras Signatur	H.	Spa	de								

BASS, WALTER

			For State Registrar	State of I	Marylan		artment of			tal Hygie	4000	13506
	Physici	an	Decedent's Name (First, Middle							ate of Death Month	Day Year	3. Time of Death
	/Medic	al .		EDWARD BAL			4h Cib. T		Apı	cil 20	2005	2:15 P M
	Examin	er	4a. Facility Name (If not institution Montgomery Cou			nital	4b. City, Town		of Death		4c. County of Deat Montgomer	
	Funeral	e Bi	5. Social Security Number			last birthday)	If Under 1 Ye	ar If Under	24 Hrs. 8. D	ate of Birth Month, Day, Ye		- Y hplace (State or Foreign buntry)
L	Director		579-54-3572	1፟፟፟፝፟M 2□F	63	Yrs.	Months Da	ys Hours	Min. (A	Month, Day, Ye	941 Wash	nington, D.C
	pur *		Usual Residence of Decedent  10a. State 10b. County		10c Cit	y, Town or Lo	cation					10d. Inside City Limits
	Maryla f sho	ō		George's		•	Joddon					1 ☐ Yes ŽIXNo
	r 28a	rec	10e. Street and Number	George 5	ПС	urel	10f. Zip Cod	е		10g.	Citizen of What Co	puntry?
	th with	Funerai Director	15305 Walker Br	anch Court			2	20707			USA	
	ems erm	ıner	11. Marital Status	12. Was Decede Armed Force	nt Ever in U	.S. 13.	Was Decedent of	of Hispanic Or	igin? (Specify )	Yes or No-	14. Race - Ame Black, Whit	
36	s afte	by Fu	1 Never Married 2 Marri 3 Widowed 4 Divorced	ed 1 ☐ Yes 2 Î lf Yes, Give	X No		1 □ Yes 2 🛭 f			, 0,0,,	Specify: Wh	
215-0036	be filed within 72 hours after death with the Maryland ital Hygiene. Id other than "natural", or items 23a or 28a-f show event, the Medical Examinant for rediffed at	ed b	15. Decedent	Year or Date	s:	16a. Dece	dent's Usual Oc	cupation		166	. Kind of Business/	
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Z Z	id 2 sho ith and 27 is mu trauma		William Michael				ng Address <i>(Stre</i> 3 Jandy				ty or Town, State, 2	Zip Code)
altimore,	f Health tem 27 other tr		20a. Method of Disposition		20b. F	_	osition (Name of matory or other)	Committee Committee College	Date	-	Location - City or	Town, State
E	Pages nent of I int: If it		1 ☐ Burial 2 🏋 Cremation  4 ☐ Donation 5 ☐ Other (Sp				ndel Cre	1	4/21/20	005	Odenton,	MD
ati	permit. Pages Department of Important: If i any injury or concept.		21. Signature of Funeral Service I	icensee							uneral Ho	
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	Physician /Medical		23a. Part1. Inter the disease, or shock, or he art failure. List immediate Cause (Final disease or condition resulting in death)	a	sed the deat i line. as a conseq	Pr	osta					Approximate Interval Between Onset and Death  2 fears
	Examiner		Cognosticity list conditions	h								
in.	P #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or	as a conseq	uence of):						
	cate be executed ohysiclan and the burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or	as a consec	uanao of\:						
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68/	ificate g phy: as the	edicai		0.		_						
O. Box	at the death certificate by the attending phys tached for use as the	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcor 1□Live birth 4□Pregnani 9□Unknowr	2 ☐ Feta at time of d	Ideath 3	Ectopic pregna Other (specify,				23d. Date of del Month	ivery Day Year
rds, P.	The law requires that the te has been signed by the sage 2 should be detache	by	Part II. Other significant conditio	ns contributing to death	n but not res	ulting in the u	nderlying cause	given in Part I	1. 2			the cause of death?
Vital Records,		Completed						·		24a. Was an autopsy performed	?   death?	itopsy findings available completion of cause of
Ita	ician: Th certificate rector, pag	Be (	25. Was case referred to medical examiner?						e of Death (Che			
	Physi this c	D	1 Yes 2 No	Hospital:		ER/Outpatier	IL 3 DOA				6 □Other (Spec	cify)
Division of	ding F h. After funera	tion	27. Manner of Death  1 Natural 5 Pending 2 Accident investig		Day Year)	28b. Time of Injury	V	njury at Vork? Yes 2		Describe how in	njury occurred	
18	or Attendi after death. Director: A in by the fu	ifica	3 ☐ Suicide 6 ☐ Could n	ot be 28e. Place of	Injury - At he	ome, farm, str	eet, factory, office			ocation (Street	and Number or Ru	ıral Route Number,
á	pital or A ours after leral Direc	Certification;	4 ☐ Homicide determi	building,	etc. (Specif	y)			0	City or Town, Si	tate)	
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director,	edicai (	29a. Certifier 1 Certifyin (Check only one) 2 Medicel E	g Physician: To the be Examiner: On the basis and manner	s of examina	wledge, death	h occurred at the vestigation, in m	e time, date ar ly opinion, dea	nd place, and d	ue to the cause the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
	with To t	Σ	29b. Signature and little of certifier					ense number	/		Date signed (Monti	*
	0,		Julia	= 1 M	N		D	516/	6	A	ril, 20,	2005
_	,,,		30. Name and address of person NUISON Kali	1. MD 18	f death (Item	1 23a) (Type,	Print)	#327	, olle,	K. MD	20832	
8	Sta Registr		31. Date tiled (Month, Day, Year) APR 2 1 20	05 Regi	strar's Signa	iture	K					

	_	1- State of Maryland / Department Certificate		ental Hygiei Reg.	2000	13507
Physicia		1. Decedent's Name (First, Middle, Last)		<ol><li>Date of Death Month</li></ol>	Day Year	3. Time of Death
/Medic		OLBUIA	rewster	April	14 2005	
Examin	er		own, or Location of Death		4c. County of Death	
		Future Care Nursing Home Balti 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1		2 Date of Birth	O Dist	(04-4
Funeral Director			Days Hours Min.	8. Date of Birth (Month, Day, Ye 01 19	21 9. Birth	place (State or Foreign ntry) est Indies
land ow		10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
Many Ff sh	ţ	MD Baltimore Randallsto	own			1 XYes 2 ☐ No
r 28g	Funeral Director	10e. Street and Number 10f. Zip C	Code	10g.	Citizen of What Cou	ntry?
th wit	a D	3838 Cherrybrook Road	21133		U.S.A.	•
dea	ner		nt of Hispanic Origin? (Spe y Cuban, Mexican, Puerto I	city Yes or No-	14. Race - Ameri Black, White	
or It	F	X Never Married 2 Married 1 Yes 27No		,	Specific	
OO DOURS	d by	3 Wildowed 4 Divorced Year or Dates:		~		Black
1215-0036 within 72 hours after death with the Maryland on the maryland sheet than "natural", or items 23a or 28a-f show the Maddell Examenation at the modified at	Completed	15. Decedent's Education (Specify only highest grade completed) (Give kind of work if the DO NOT use	Occupation done during most of workii retired)	ng 16b	. Kind of Business/Ir	ndustry
212 ad withil giene. er than	gmc.	Elementary/Secondary (0-12)   College (1-4or 5+)	Assistant		rivate 1	Duty
Hygin Hygin	င္ပ	17. Father's Name (First, Middle, Last)		(First, Middle, Maid		
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Maryland of 2 should be fille th and Mental Hy 27 is marked oth treumatic event	F		Street and Number or Rura			
Ma alth al lith al 27 Is 27 Is			rybrook Roa			
R 1 au f Hear item othe		20a. Method of Disposition 20b. Place of Disposition (Name	A STATE OF THE PARTY OF THE PAR		. Location - City or T	
Page ento		1 XBurial 2 □ Cremation 3 □ Removal from State  '4 □ Donation 5 □ Other (Specify)  King Memoria		9/2005 B	tandalls	town, Md
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filled within 72 hours after death with the Marylan Inspertment of Health and Mantal Hygiene. Impertants if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other treumatic event, it was injury or other treumatic event, it was injury or other treumatic event.			Address of Facility F/H West	7 2000 2		,
Dal permi Depa Impo any is		Y XUMMUM CARMINANT 4300 W	abash Ave,	Baltimo	ore, Md	21215
Physician /Medical Examiner		23a Parl . Enter the disease, or complications that cause the death. Do not enter the mode style, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):  Sequentially list conditions.	VASCULAL	U62		Approximate Interval Between Osset and Death
Records, P.O. Box 68760, The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Urdenting Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d.				
IS, P.O. Box 6 res that the death certifit signed by the attending to be detached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnant at time of death 5 ☐ Other (special death section)			23d. Date of deliv Month	ery Day Year
Cords, P. w requires that been signed bishould be deta	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cau	use given in Part I.	23e. Did tobace	co use contribute to	
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Vital rsiclen: T s certificat director, ps	Be	25. Was case referred to medical examiner?	26. Place of Death	A contract of	10 mm	
on of sing Phy	tlon: To	1   Tes 2   NO   1   Inpatient 2   EH/Outpatient 3   DOA		ne 5 Residence 28d. Describe how i	e 6 ⊡Other (Speci njury occurred	(fy)
Division tel or Attending s after death. el Director: Afte ed in by the fune	Certification:	3 Suicide 4 Homicide  6 Could not be determined  28e. Place of Injury - At home, farm, street, factory, building, etc. (Specify)	office	28f. Location (Stree City or Town, S	t and Number or Rur tate)	al Route Number,
Divisit To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical	29a. Certifier (Check only one)  1 Certifying Physicien: To the best of my knowledge, death occurred at 2 Medical Examiner: On the basis of examination and/or investigation, in and manner stated.  29b. Signature and title of certifier 29c.	n my opinion, death occurre	ed at the time, date	and place, and due t	o the cause(s)
	_	290.	12756	9	4/18/0	Say, rear)
<b>b</b>	-	29b. Signature and title of certifie 29c.  30. Name and addless of person who completed cause of death (Item 23a) (Type, Print)  1878  31. Date filed (Month, Day, Year)  APR 2 1 2005	6 Greene	Tree	Rd	21208
Sta Registr		APR 2 1 2005				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 13508 AMEND ITEM #23b PERPHY G842 47 1/2 405 of Peath 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year 230 PM 2005 Ida Regina Buser 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Belcame

If Under 1 Year If Under 24 Hrs. 48, Date of Birth

Month, Day, Year)

Feb. 22, 1911 4c. County of Death (0) Kiverside arford orien 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 ☐ M 2 🖫 F Mary Land Yrs. 94 220-48-8789 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Maryland Harford Joppa 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 423 Philadelphia Road 21085 **USA** 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: 3 Widowed 4 □ Divorced Specify: White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 8 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) William Bennit Langley Julianna Murphy (nmn) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2509 Chilberry Ave., Joppa, MD 21085 Barbara M. Maines / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Bel Air Memorial Grdns 4-20-05 Bel Air, Maryland \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur y if Funeya Service Licenses 22. Name and Address of Facility.
McComas Funeral Home, P.A. de 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cadse on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ue to (o as a consequence of): disease or condition resulting in death) FEW DAYS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last CONGESTIVE HEART FAILURE Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tyes 2 No 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy
performed?

1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Aursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

The law requires that the death certificate be executed attending | o the detached δ signed I Records, peeu certificate Vital jo this After thi Division Attending death. 0

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**Physician** 

/Medical

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Certification:

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29a. Certifier

(Check only one)

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Items 23a

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Department of Health a Importent: If Item 27 Is any Injury or other tree

Physician

/Medical Examiner

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Pages 1 and 2 should

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2121 fited within 7 Hygiene.

Maryland

Baltimore,

(4)

State Registrar

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

ress of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed

. Registrar's Signature

within 24 hours aft

To the Funeral DI

completely filled in

			For State Registrar	State of	Maryland	d / Depa		t of H	ealth a				005	135	509
	Physici		1. Decedent's Name (First, Middle, L	ast)							2. Date of Dea	_	Year	3. Time of	Death
	/Medic		DAVID						UM		APRIL	18	2005°	2:50	Рм
	Examin	er	4a. Facility Name (If not institution, g 7 OAK HOLLOW COI		nber)				Location of	of Death			ounty of Death		
	Funeral			Sex	7. Age (In yrs. la	ast birthday)	If Under		RE If Under	24 Hrs.	8. Date of Birt		LTIMORE 9. Birth	place (State o	r Foreian
	Funeral Director		219-50-1278 Usual Residence of Decedent	1 <b>X</b> M 2□F	56	Yrs.	Months	Days	Hours	Min.	8. Date of Birt 09/13/	1948	Cou	ntry) MD	
	yland how		10a. State 10b. County			, Town or Lo					·-,			10d. Inside C	ty Limits
	Ba-f s	ctor	MD BAL	ΓIMORE	B/	ALTIMO	RE							1 🗌 Yes	2 No
	with the	Funeral Director	10e. Street and Number 7 OAK HOLLOW COI	IDT			10f. Zip	<sup>Code</sup> 208					S.A.	ntry?	
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21215-0036	72 hor	Completed	15. Decedent's (Specify only highest of	Education		16a. Dece	dent's Usua kind of wor	l Occupa	ition	t of work	ina	16b. Kind	d of Business/Ir	ndustry	
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7	filed w Hygiei ther ti		17. Father's Name (First, Middle, Las	5+		ATT0	KNEY		18 Mothe	r's Name	(First, Middle,	Maiden S	LAW		
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E O	Pages ent of nt: If I		1 🕅 Burial 2 □ Cremation 3 3 4 □ Donation 5 □ Other (Special Control of the Co		State	emetery, crer			* 1	04/2	0/2005	RAN	DALLSTO	MN MD	
Baltimore,	perrit. Departm Importe any nju		21. Signature of Funeral Service Lic		, 521		. Name an				LEVINS				
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Vita	ysician: The is certificate hi director, page	Be	25. Was case referred to medical examiner?	Manaidali				101			(Check only o				
of	Physic this cral dir	٠ <u>۲</u>	1 Yes 2 No  27. Manne of Death			ER/Outpatien		A Othe	1. 4 □ Nu		me 5 X Resid			(y)	
O	ding F. h. After funera	tion	1 Natural 5 Pending 2 Accident investigati		f Injury b, Day Year)	Injury	M	Bc. Injury Work	at ? ′es 2 □ !		zeu. Describe n	ow injury	occurred		
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_	Hospite 24 hours Funerel	Medical C	29a. Certifier 1 Certifying I	Physician: To the aminer: On the ba	sis of examinati	wledge, death	occurred a	at the tim	e, date and inion, deat	d place, a	and due to the ded at the time, d	ause(s) a	nd manner as s lace, and due t	tated. the cause(s	)
	ro the	Mec	29b. Signature and the of certifier	and mann	) or stated.				number			29d. Date	signed (Month,	Day, Year)	
	- > - 0		hu	LA Th	C (3)	8		P4	4 29	20	nde 200	19	April.	2000	
	011		30. Name and address of person wh	o completed cause	of death (Item	23а) (Туре,	Print)					1	1	210	93
	24		1 moth	L 160	he 1 16	765	tall	s K	0005	185	de 200	Lot	tor unl	le mi	2
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			1 - For State Registrar	State of Man	yland / Depa	artment of H	lealth a	•		005	13510
			Decedent's Name (First, Middle, La	st)		timodio or i	Journ	2. Date of			3. Time of Death
	Physici		Lillian Cor	evieve Crou	50			Month	Day		6:30а м
	/Medic Examin		4a. Facility Name (If not institution, give		56	4b. City, Town, or	Location of	Apri Apri		2005 County of Deat	h
	- Admini	Ü	2 McIntosh Court	Apt. E		Catons	sville			Baltim	ore
	Funeral		5. Social Security Number 8. S	Sex 7. Age (/	In yrs. last birthday)	If Under 1 Year Months Days		4 Hrs. 8. Date of	Birth Day, Year)		hplace (State or Foreign untry)
	Director		214-05-1298	1□M 2XF	88 Yrs.	Months Days	Hours	AUG 1			ryland
	DG ≱		Usual Residence of Decedent  10a. State 10b. County	1	0c. City, Town or Lo						
	shov	5			oc. City, Town or Lo	cation					10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	28a-f	ect	Maryland Baltin  10e. Street and Number	ore		Catons	sville		10- 0%		
	with a or	ត់		t Ant E		10f. Zip Code	220		Tog. Cit	izen of What Co	untry?
	death with the Maryland ms 23a or 28a-f show rmust be notified at	Funeral Director	2 McIntosh Cour	12. Was Decedent Eve	er in U.S. 13		228	in? (Specify Yes or	No-	USA 14. Race - Ame	rican Indian
_	r Iten	표	1 ☐ Never Married 2 Married	Armed Forces?		f Yes, specify Cuba	n, Mexican,	in? (Specify Yes or Puerto Rican, etc.)		Black, White	
2	urs a	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2X No	Specify:			Specify:	White
2-003p	within 72 hours after ene. then "naturel", or ite te Midical Examine	Completed	15. Decedent's E (Specify only highest gr	ducation	16a. Dece	dent's Usual Occupa	ation	of working	16b. Ki	ind of Business/	Industry
N	thin .	npie	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	kind of work done of DO NOT use retired	i)	Gr WOIKING			
V	be filed within 72 hours after death with the Maryian tal Hygiene. d other then "naturel", or liems 23a or 28a-1 show event, Ira Madical Examiner must be notified at	ပ်	10		H	omemaker				omestic	
yland	be fill	Be	17. Father's Name (First, Middle, Last					's Name (First, Midd		Sumame)	
<u>}</u>	2 should be and Mental Is marked eumatic ev	ပ္	Herbert Norf					emima Coo	<u> </u>		
<u>a</u>	12 sh h and 7 Is m		Normant's Name/Relationship					or Rural Route Num  E Cato:			
a)	it. Pages 1 and 2 should ritment of Health and Men ritant: If Item 27 Is marke njury or other treumatic		20a. Method of Disposition					Date	_	cation - City or	
בַ	Pages nent of int: If It		1 Burial 2 Cremation 3	Themoval mom State	20b. Place of Dispo					-	
Baltimor	mit. Pages pertment of portant: If It injury or o		* 4 ☐ Donation 5 ☐ Other (Speci 21. Signature of Funeral Service Lice			ematory,				Baltimo	re, MD
g n	permit. Departitions in points any night		* * * MMJ CC VIII	Malo	Ć	remation	Socie	ty of Mar	y1and	, Inc.	
			23a, Part1, Enter the disease, or con		e death. Do not ent	99 Freder	rick R	oad Ralt	imore	, MD 21:	228 Approximate
	Met L		23a. Part1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final	one cause on each line.		/ - 1	1 1	/ /	urrost,		Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Gast.	~ Inte	timal	ble	eed ing			2 months
	Examiner			Due to (or as a c	consequence or):	Vania	4000	eeding			2 mondo
		e.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (of as a c	consequence of):	VIVOICE	0				2 mondy
	uted d ansit	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events								
<b>-</b>	be executed ician and burial-transit	Еха	resulting in death) Last	Due to (or as a c	consequence of):						
00/	ate be executed hysician and the burial-transit	cai		_ d							
B	death certificate a attending physi d for use as the	9	15.551.11.5						4		
Š	Jeath certific attending p	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of 1 ☐ Live birth 2 [		Ectopic pregnancy			1 :	23d. Date of deli	
מ	he att	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐ Pregnant at tim		Other (specify)			-	Month	Day Year
٦	uires that the de signed by the a Id be detached f	Phy	9 Unknown					1			
ທົ	law requires that as been signed b 2 should be deta	by	Part II. Other significant conditions	contributing to death but r	not resulting in the u	nderlying cause give	en in Part I.				the cause of death?
cords	w requir been s should	ted							Yes 2	No 3□Pro	obably 4 Unknown
ပ္	e law has b	ompleted							topsy	prior to d	topsy findings available completion of cause of
=	Th ate pag	S						pe 1 ☐ Yes	rformed? 2 X No	death?	2□ No
N I I I	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Unanital:		211		of Death (Check onl	y one)		
10	8 S =	5	1 Yes 2 No	Hospital:			4 🗀 (40)	sing Home 5 X Re			city)
	ding Phy h. After thi funeral o	lon	1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Y	(ear) 28b. Time o	Worl		28d. Describ	e now injur	y occurred	
Vision	death death ctor: / the	ical	2 Accident investigation 3 Suicide 6 Could not to	OP Place of Injury	- At home farm etc		Yes 2 □ N		(Stroot an	d Number or Ru	ral Route Number,
<u> </u>	l or At after d Direct in by	Certification:	4 Homicide determined	building, etc. (	(Specify)	eer, raddry, onide			own, State		rai riodie ivanibei,
	To the Hospitel or Attending within 24 hours after death.  To the Funerel Director: After completely filled in by the fune		29a. Certifier 1X Certifying P	hysician: To the best of r	ny knowledge, deat	h occurred at the tim	ne, date and	place, and due to the	ne cause(s)	and manner as	stated.
	e Ho 124 h	edical	(Check only Medical Exa	miner: On the basis of ex and manner stated	kamination and/or in	vestigation, in my op	pinion, death	n occurred at the tim	e, date and	place, and due	to the cause(s)
	withir To th	Me	29b. Signature and title of certifier			29c. License			29d. Dat	e signed (Month	n, Day, Year)
	/		Pakat X.	Givaro		D3	1721	0	4-	21-0	5
	'n		30. Name and ad let's of person who	completed cause of deat	th (Item 23a) (Type,	Print)	7		1	,	em021228
	V		Raafat Y.	Girais	724	Maider	1 Ch	vile la.	Cert	owsvil	le MD 21228
	Sta		31. Date filed (Month, Day, Year)	32 Registrar's	Signature						
	Registi	ar	APR 2 1 20	U5 States	J. As	and .					

			State of M  State of M  Registrar	aryland / Dep <i>Ce</i>	artment of He		, ,	ene 2. No. 0 0 5	13511
			Decedent's Name (First, Middle, Last)				2. Date of Death		3. Time of Death
	Physicia /Medic		Agnes Theresa C	ahill			APRIL 20	Day Year O. 2005	8:50p M
	Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or L	ocation of Death		4c. County of Dea	
			Manor Care Potomac		Potom	ac		Montgome	CV
	Funeral			ge (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	9. Bir	thplace (State or Foreign
	Director		046-05-9867 1 <sup>DM</sup> 2 <sup>T</sup> X	100 Yrs.	Months Bays	Tiodis Willi.	FEB 7,		necticut
	DC >		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or L	anation.				dod Inside Other Limite
	shov	_		Toc. City, Town or E	ocation				10d. Inside City Limits 1 Yes 2 No
	38a-1	octo	Maryland Montgomery		Potomac		T		
	with the	Directo	10e. Street and Number		10f. Zip Code	0051	10	g. Citizen of What Co	ountry?
:	s 23	Funerai	9727 Avenel Farm Drive	F		0854	7 7 1	USA	- Lander
	ltem Item	un.	11. Marital Status  12. Was Decedent Armed Forces: 1 Never Married 2 Married 1 Yes 2 M	Ever in U.S. 13.	Was Decedent of His If Yes, specify Cuban	, Mexican, Puerto	Rican, etc.)	14. Race - Ame Black, Whit	
گ ب	rs aff	by F	3 Widowed 4 Divorced Year or Dates:	140	1 ☐ Yes 2X No	Specify:		Specify:	White
2-003p	iled within 72 hours after death with the Maryland Hygiene. Hydiene. Inter then "natural", or items 23a or 28a-f show int, the Medical Examinar must be notified at		15. Decedent's Education	16a. Dece	edent's Usual Occupat	ion	110	5b. Kind of Business	/Industry
2	n in in	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or	life.	e kind of work done du DO NOT use retired)	iring most of worki	ng		
7	d with	E O	8		emaker			Own I	Home .
and	othe	0	17. Father's Name (First, Middle, Last)		1	18. Mother's Name	(First, Middle, Ma		
<u>a</u>	Aenta Aenta Ilc e	To B	William P. Burns			Mary 1	Lamb		
Mary	and N		19a. Informant's Name/Relationship (Type, Print)		ing Address (Street ar				Zip Code)
Σ.	and alth		Maureen Altobello/daughte	r 9/2/	Avenel Fa	rm Dr.	Potomac,	MD 20854	
e e	of He	1	20a. Method of Disposition 1 □ Burial 2X Cremation 3 □ Removal from State	20b. Place of Dispersion Communication Communication (Communication)	osition (Name of matory or other place)	)	ate 20	Oc. Location - City or	Town, State
Ĕ,	Pag nent ary o		*4 □Donation 5 □Other (Specify)	Metro Cre	ematory, I	nc. 4/21,	/05	Baltimor	e, MD
Baltimor	permit. Pages 1 and 2 should be liled within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. In important: If term 27 is marked other then "natural; or Items 29a or 28a-f show any Injury or other traumatic event, in a Medical Examinat must be notified at once.		21. Signature of Funeral Service Ligensee	1 2	2. Name and Address remation	of Facility	of Maryla		
n	8.0 5 5 9	1	Dawn F. McDonald	1	299 Freder	ick Road	Raltimo	ore. MD 21	228
	20		23a. Part1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each li	the death. Do not en	ter the mode of dying,	, such as cardiac o	r respiratory arres	it,	Approximate Interval Between
F	hysician		Immediate Cause (Final disease or condition Senile	Dementia					Onset and Death
	/Medical		resulting in death)	a consequence of):					5 yrs
	Examiner	.	Sequentially list conditions.						
1	sit o	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Leass of injury	a consequence of):					
	and tran-	каш	that initiated events c.	a consequence of):					
) (0)	sate be executed shysician and the burial-transit	aiE	oue to (or as	a consequence on).					
0	certificate be executed ding physician and use as the burial-transit	<u>.</u> 2	d						
×	w requires that the death certifics been signed by the attending pt should be detached for use as t	Physician/Med	IF FEMALE: 23c. If yes, outcome	of pregnancy				201 0-1-11	
XOO !	death death de atten	ian	in the past 12 months?	2 Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of del Month	Day Year
o i	the d	ysic	1 ☐ Yes 2 No 4 ☐ Pregnant a 9 ☐ Unknown 9 ☐ Unknown	time or death 5					
ŗ. ]	iaw requires that the as been signed by the 2 should be detached		Part II. Other significant conditions contributing to death b	out not resulting in the u	underlying cause given	in Part I.	23e. Did toba	cco use contribute to	the cause of death?
S	ures sign Id be	d by	Atrial Fibrillation, Hype	ertention,	Hypothyroi	idism,	1 ☐ Yes	2 X No 3 □ Pr	obably 4 🗀 Unknown
ecords	w req beer shou	lete	Danish and III I				24a, Was an	24h Wara au	topsy findings available
	Physicien: The lav this certificate has al director, page 2 :	Completed	Peripheral Vascular Disea	ise			autopsy	prior to	completion of cause of
	n: II ficate or, pa	e Co	25. Was case referred to medical				1 ☐ Yes 2X	J No 1 LI Yes	2 No
<b>5</b>	cert irect	o Be	examiner?	ent 2 ER/Outpatie	Other	26. Place of Death			
5	After this funeral di	$\vdash$	1 ☐ Yes 2 ☐ No 1 ☐ Inpation  27. Manner of Death 28a. Date of Inju 1 ☐ Natural 5 ☐ Pending (Month, Da				ne 5∟Hesiden 28d. Describe how	ce 6 Other (Speringury occurred	city)
IVISION	Attending Physicien: It death. ector: After this certific by the funeral director.	ertification;	1 Natural 5 Pending (Month, Da 2 Naccident investigation	y Year) Injury		es 2 □No			
2	Attender death cotor:	fice	3 Suicide 6 Could not be	ury - At home, farm, st	reet, factory, office	2	28f. Location (Stre	et and Number or Ru	ıral Route Number,
=	alor afte din t	ert	4 Homicide determined building, ei	c. (Specify)			City or Town,	State)	
	spita hours inere	alC	29a. Certifier 1 X Certifying Physician: To the best	of my knowledge, deat	th occurred at the time	, date and place, a	and due to the cau	se(s) and manner as	stated.
	To the Hospital of Attends within 24 hours after death.  To the Funerel Director: A completely filled in by the fu	edical	(Check only one) 2 Medical Examiner: On the basis of and manner st	t examination and/or in ated.	vestigation, in my opir	nion, death occurre	ed at the time, dat	e and place, and due	to the cause(s)
	withi To the	×	29b. Signature and title of certifier		29c. License i	number	290	d. Date signed (Mont	h, Day, Year)
	\$		29b. Signature and title of certifier  And Thomas M.D.		D005	3615		April 21	2005
	X		30. Name and address of person who completed cause of o	leath (Item 23a) (Type,	Print)				2010
			Aruna Nathan, M.D. 11125	Rockville	Pike_#208	Rockvil	le, MD 2	0852	
	Sta		Aruna Nathan, M.D. 11125 31. Date filed (Month, Day, Year) APR 2 1 2005	ar's Signature	M)		,	-	
	Registr	ar	APR 2 1 2005	1.5 13 Page	\$1.7				

			For State Registrar	State of Mar	yland / Depa <i>Cei</i>	artment of F rtificate of			ene g. No. O o o o	
	hysici		Decedent's Name (First, Middle, Last)  Leo John					2. Date of Death Month April 9	Day Year	9:17 P M
	/Medic Examin		4a. Facility Name (If not institution, give s Frederick Memo	street and number)	tal		or Location of Death	APILI	4c. County of Deat	
	uneral rector		502-38-6883	7. Age (	(In yrs. last birthday) 65 Yrs.	If Under 1 Year Months Days		8. Date of Birth (Month, Day, JUNE 19,	Year) 9. Birth Co 1939 NORT	nplace (State or Foreign untry) 'H DAKOTA
the Maryland	28e-f show	Director	Usual Residence of Decedent		Oc. City, Town or Lo			10	g. Citizen of What Co	10d. Inside City Limits 1 ☑ Yes 2 ☐ No
:1215-0036 within 72 hours efter deeth with the Maryland ene.	is marked other then "netural", or liems 23e or 28e-f show eumatic event, tre Medical Exertirer must be notified at	by Funeral	5550 JAMES STREET	12. Was Decedent Ev. Armed Forces? 1  ☐ Yes 2  ☐ No If Yes, Give	1	34652 Was Decedent of H	dispanic Origin? (Span, Mexican, Puerto	ecify Yes or No-	U.S.A.  14. Race - American Black, White	nican Indian, a, etc.
Maryland 21215-0036 of 2 should be filed within 72 hours ef the and Mental Hygiene.	r then "neture tre Medical E	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)		(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of work	ing 1	6b. Kind of Business/I	ndustry
ryland 2 hould be filed d Mental Hygid	marked othe matic event,	To Be C	17. Father's Name (First, Middle, Last)  ROBERT LYNCH  19a. Informant's Name/Relationship (Ty)	na Print)	10h Maili	- Address (Chroat	ANN UNO	e (First, Middle, M. BTAINABLE	aiden Sumame)	- O- 4-)
ore, Ma es 1 and 2 s of Health an	Importent: If item 27 is marked any njury or other treumatic ev once		CHRISTINE E. CLARI  20a. Method of Disposition  1   □ Burial 2 □ Cremation 3 □ R	K - WIFE		JAMES ST	TREET NEW	PORT RIC	City or Town, State, 2  HEY, FL 34  Oc. Location - City or 1	652
Baltimore, permit. Pages 1 ar Depertment of Hea	Importent: I any njury o once.		'4 □ Donation 5 □ Other (Specify)  21. Signature of Emeral Service □ Cens	emoval from State	NATIONAL 22	MEMORIAL  . Name and Addre	PARK 4/	ATIONAL F	FALLS CHURG UNERAL HON	1E
Phys	sician edical		23a. Part1. Priter the disease, or com, y shock, or hear failure. List only Immediate Cause (Final disease or condition resulting in death)	Cardia	ac acr	er the mode of dyir			CH, VA Z20 st.	Approximate Interval Batween Onset and Death Nows
Exa	physician and stransit street burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due Verasa	consequence of):	on				years
Box 6	led by the attending pl detached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of 1 Live birth 2 ( 4 Pregnant at tin 9 Unknown	Fetal death 3	Ectopic pregnancy	у		23d. Date of delin	very Day Year
Records, Pone law requires that	been signed by should be deta	by	Part II. Other significant conditions con	ntributing to death but r	not resulting in the ur	nderlying cause giv	ven in Part I.		cco use contribute to	,
	ate has page 2	Completed	preumonia,	Anoxio	c'enc	ephalo <sub>0</sub>	pathy	24a. Was an autopsy performe	24b. Were aut prior to c death? 1 \( \text{Yes}	opsy findings available ompletion of cause of
on of	: After this certificate e funeral director, paç	atlon; To Be	25. Was case referred to medical examiner?  1  Yes 2 No H  27. Manner of Death 1 Natural 5 Pending investigation	lospital: 1 Inpatient 28a. Date of Injury (Month, Day Y	2 ER/Outpatien 28b. Time of Injury	28c. Injur Wor	er: 4 \( \text{Nursing Ho}	th (Check only one) me 5  Residen 28d. Describe how	ce 6 Other (Spec	ify)
DIVISIO To the Hospitel or Attendi	rej Director led in by the	Certification;	3 Suicide 6 Could not be determined	building, etc. (				City or Town,		
thin 24 hou	To the Funerej Dis completely filled in	Medical	29a. Certifier (Check only one)  1 ☑ Certifying Phys 2 ☐ Medical Examir 29b. Signature and title of certifier	sician: To the best of r ner: On the basis of ex and manner stated	xamination and/or inv	r occurred at the tir restigation, in my o	pinion, death occur	red at the time, dat	e and place, and due	to the cause(s)
Z Š I	) F 8		· m	mpleted cause of deat	th (Item 23a) (Type		_		d. Date signed (Month) April 9 Ck	
:	Sta Registr		Fauzi Rizvi, 31. Date filed (Month, Day, Year)  APR 2 1 201	MD; 400	West-	7th Sty	nget, Fr	rederi	ck	

			For	State of Marylan		nt of Health and	_		_	
			1 - State Registrar			ite of Death		Reg. No.	< U 11 5	13513
	Physici	an	1. Decedent's Name (First, Middle, Las				2. Date of D Month	eath Day	y Year	3. Time of Death
	/Medi	cal	1	a Cooke		y, Town, or Location of Dea	4	7	County of Dog	0432 A M
	Examir	ner	4a. Facility Name "(If not institution, give	PLACE	10.00	BALTIMO	RE	46.	County of Dea	un
	Funeral		5. Social Security Number 6. Se	7. Age (In yrs.	Month	er 1 Year If Under 24 Hr s Days Hours Mir		irth	9. Bir	rthplace (State or Foreign ountry)
	Director		Usual Residence of Decedent	JW 201 8	Yrs.	,	8/4/	15	PEN	UNSYLVANIE
	yland		10a. State 10b. County	10c. Cir	ty, Town or Location			<del></del>		10d. Inside City Limits
	e Mar ga-f sl	ctor	AZ MARI	COPA S	COTTE	3DALE				1 Nes 2 No
	with the	Funeral Director	10e. Street and Number	DINOC	10f. 2	Cip Code		10g. Citi	zen of What C	ountry?
	death ms 23	eral	11. Marital Status	12. Was Decedent Ever in U	J.S. 13. Was Dec	edent of Hispanic Origin? (	Specify Yes or N	10-	14. Race - Am	OIHIES erican Indian,
99	or ite	Fur	1 Never Married 2 Married	Armed Forces?  1 Yes 2 No If Yes, Give		2 No Specify:	rto Rican, etc.)		Black, Whi	te, etc.
215-0036	within 72 hours after death with the Maryland ene. than "natursi", or items 23a or 28a-f show ta Maifeil Examiner must be notified at	ed by	3	Year or Dates:	16a. Decedent's Us			16h V		JAN 11 C
215	hin 72 9. In "na Mole	Completed	(Specify only highest grad		(Give kind of v	vork done during most of w	orking	16b. KI	nd of Business	vindustry
7	filed with Hygiene. other than	Соп		5+	TEAC	HER_			MENT	ary ochool
and	ould be fit Mental H arked oth	Be	17. Father's Name (First, Middle, Last)	BARRON	1	18. Mother's N	ame (First, Middl	e, Maiden	Sumame)	111
Maryland	2 should and Men is marke surmatic	은	19a. Informant's Name/Relationship (7		19b. Mailing Addre	ss (Street and Number or F	Rural Route Num	ber, City o	r Town, State,	Zip Code)
_	1 and 2 Health a em 27 is		DIANNE ROSS	LNIECE	300 ST	DUNSTEA	HUS RI	).B	HUIMD	RE MD alal
Baltimore,	t t		20a. Method of Disposition 1 Burial 2 Cremation 3	Removal from State	Place of Disposition (N cemetery, crematory of	ame of other place)	Date	20c. Lo	cation - City or	Town, State
Ħ	permit. Pag Department Important: i any injury o once.	10	* 4 Donation 5 Other (Specify 21. Signature of Fundamental License	N VI	ATOMY GIF	15 KEG. 147 and Address of Facility	7/05	HA	NOVE	JR, MD
Ba	permit. Departn Imports any inju	0	N. H. Sal	int		augherty Family Funeral	Home And Cr	emation (	Center, P.A.	
			23a. Part1. Enter the disease, or composhock, or heart failure. List only of	olications trial caused the deat	th. Do not enter the m				1126	Approximate Interval Between
5	Physician		Immediate Cause (Final disease or condition resulting in death)	a	enen tr					Onset and Death
1	/Medical Examiner			Due to (or as a consec	quence of):					
	جيد	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a consec	quence of):					
	ecuted and -transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c						
8760,	law requires that the death certificate be executed as been signed by the attending physicien and 2 should be detached for use as the burial-transit	icai E	Total and the second se	Due to (or as a consec	quence or):					
9	ifficate g phys as the	ed		d						
Вох	leath certific attending pl	Physician/M	1F FEMALE: 23b. Was decedent pregnant in the past 12 mg/ths?	23c. If yes, outcome of pregnature 1 ☐ Live birth 2 ☐ Feta		pregnancy		2	23d. Date of de	
-	the at	ysici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of o 9□Unknown	death 5 Other (	specify)			Month	Day Year
, P.O.	res that the de signed by the a be detached f	by Ph	Part II. Other significant conditions co	ontributing to death but not res	sulting in the underlying	cause given in Part I.	23e. Did	tobacco u	se contribute t	o the cause of death?
of Vital Records,	w requires been sign should be	ted b					1	Yes 2[	No 3□P	robably 4 Unknown
ecc	has be	Completed					24a. Wa	opsy	prior to	utopsy findings available completion of cause of
al B	The ate						1 ☐ Yes		death?	s 2□No
Z.	Physician: this certificatal director,	To Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3 1		eath (Check only		Other (Sne	scity) Gather's Mace A:
n of	<u>- 6</u>	T:uc	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe			city) ope 4 37 -certs
Division	Attending Planding Pl	catio	2 Accident investigation 3 Suicide 6 Could not be		М	1 ☐ Yes 2 ☐ No	1			
Divi	after of Direction by	Certification:	4 Homicide determined	28e. Place of Injury - At h building, etc. (Special	nome, farm, street, factority)	ory, office	28f. Location City or To	(Street and own, State	d Number or R )	ural Route Number,
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the t	Medical C	29a. Certifier (Check only one) Certifying Physical Example)	ysician: To the best of my kno ninar: On the basis of examina and manner stated.	owledge, death occurre ation and/or investigation	d at the time, date and place on, in my opinion, death occ	ce, and due to the curred at the time	e cause(s) o, date and	and manner a place, and du	s stated. e to the cause(s)
	To the Within To the	Me	29b. Signature and title of certifier	and marinor states.	2	9c. License number		29d. Dat	e signed (Mon	th, Day, Year)
	/		> Just Bun	~~		00059189		411	5105	
	15		30. Name and address of person who of	completed cause of death (Iter	m 23a) (Type, Print)	20/L====================================	200			
	Sta	l ate	31. Date filed (Moprin Day: Year) 200	2. Registrar's Sign	ature _	altimen mp	21211	-		
	Regist		HLK Z I 500	5 Blown to	books					

State Registrar

Day.

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year 40 **Physician** William C. Chinault PR 205 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore n/a KESWICK MULTICARE 8. Date of Birth (Month, Day, Year) May 15, 19 If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 X M 2 □ F 214-03-5189 Yrs. 87 Director Maryland Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits 10a. State rai', or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 No Maryland n/a Baltimore Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1013 Overbrook Road 21239 United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. filed withIn 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 ₩ Widowed 4 Divorced "natural". 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) traumatic evant, the Medical 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) d 2 should be filed withln 7 th and Mental Hygiene. 7 Is markad othar than "r Elementary/Secondary (0-12) College (1-4or 5+) 12th Bus Driver Mass Transit 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William W. Chinault Catherine McNamara 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 sl ment of Health an ant: If Item 27 Is 1 Claudia L. Ittenbach daughter 1019 Overbrook Road Baltimore, MD othar 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Important: If any injury or once. Gardens of Faith Cem. April 23, 2005 Baltimore, MD \* 4 □ Denation 5 □ Other (Specify) 22. Name and Address of Facility
Burrier-Queen Funeral Home & Crematory, PA
1212 W. Old Liberty Road Winfield, MD 21/84 21. Signature of Funeral Service Licensee Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ck, or heart failure. List only one cruse on each line. Approximate Interval Between Onset and Death hiate Cause (Final **Physician** ase or condition resulting in death) Sdays /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner The law requires that the death certificate be executed use as the burial-transit s been signed by the attending physician and should be detached for use as the burial-trar resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown Part IJ other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed?
1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has t certificate Physician: director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Warsing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To this funeral Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Hospital or Attanding Injury 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation after death Director: / the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital of within 24 hours at To the Funeral D Propertifying Physician. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mainter as stated. 29a. Certifier Medical 2 Medical Examine: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2001 8 30. Name and ddress of pur (Item 23a) (Type, Print) who completed DSE 31. Date filed (Month, Day, 32 Registrar's Signature State 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** 4:10 P William Howard Curtis April 19 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Gilchrist Towson <u>Baltimore</u> If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days 1 M 2 F Hours Min Yrs Director 20 1926 077-18-9065 78 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits rel', or items 23a or 28a-f show Exercicer must be notified at 1 ☐ Yes 2 No MD Baltimore Directo Freeland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2705 Flintstone Rd. 21053-9746 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1▼DYes 2□No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. s 1 and 2 should be filed within 72 hours after aft Health and Mental Hygiene.
Item 27 is marked other then "neture!" A termon 1 Never Married Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: white Specify: 3 ☐ Widowed 4 ☐ Divorced The Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 12 5+ School Teacher Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 Howard Holbrook Curtis Viola Cosby 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret Alice Jones Curtis/wife 2705 Flintstone Rd., Freeland, MD 21053-9746 other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Lemit, Pages 1 Department of H Importent if Ite any injury or ot 4 Burial /2 Cremation 3 □ Removal from State ( 4 □ Donation ( 5 □ Other (Specify) Balto. Wash. Crematory 4/21/05 Laurel, MD <sup>22, Name and Address of Facility</sup>
Lemmon Funeral Home of Dulaney Valley,
10 W. Padonia Rd., Timonium, MD 21093 Inc. Lowell M. Lemmon 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ceakemia nontas **Physician** Chronic myelomaciocytic disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) been signed by the attending physician and should be detached for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): 68760 Physician/Medical Box ( IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 4 Pregnant at time of death 5 Other (specify) o 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? page 2 s autopsy performed certificate 2 No 1 Yes 1 Tyes of Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence Certification: To 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 6 Other (Specify) NQS 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? After Division Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No death. the Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide within 24 hours after To the Funerel Dire ō the Hospital 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) APALL st Dalfinos W Name and address of person who com 660 Gara J Charles 31. Date filed (Month, Day, Year) 32. Registrar's Sig State Registrar

DHMH 17 Rev 1/2001

Registrar

2005

		For State Registrar		State	of Mar		artment of I		nd Mental Hy	giene (	105	13518
٥.		1. Decedent's Name	(First, Middle, La	ist)					2. Date of Do Month	eath Day	Year	3. Time of Death
Physici /Medic		Albert				Degman			April	19	2005	10:10 рм
Examir	ner	4a Facility Name (It 610 Maid St. Mart	not institution, gir len Choic	e street and n	umber)		4b. City, Town,	or Location of [	Death		unty of Death	
							-	onsvill			Baltim	
Funeral		5. Social Security No. 212-22-8		Sex 1X□M 2□F	7. Age	(In yrs. last birthday, 77 Yrs.	Months Days		Min. 8. Date of Bi (Month, D Sep. 1	rth a <i>v. Year)</i> 2, 192	9. Birth	place (State or Foreign oftry) yland
Director		Usual Residence of							bep. 1	2, 172	, Har	y I dilu
yland		10a. State	10b. County			IOc. City, Town or L	ocation				1	10d. Inside City Limits
ith the Marylan or 28a-f show	Director	MD	Balt	imore		(	atonsvil	le				1 ☐ Yes 2X No
ith th	Oire	10e. Street and Num					10f. Zip Code			10g. Citizen	of What Cou	ntry?
ath w	E E	610 Maid	en Choic					21228			ited S	
iled within 72 hours effer death with the Maryland Hygiene. Hygiene. Wher then "natural, or items 23s or 28s-f show ent. The Mixical Ex. of the invite or 18s-f	by Funeral	11. Marital Status  1 Never Marrie  3 Widowed	ed 2 Married 4 Divorced	12. Was De Armed I 1 AYes If Yes, G Year or	Forces? 2 □ No Sive	er in U.S. 13.	Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 2 No		n? (Specify Yes or N Puerto Rican, etc.)		Race - Americ Black, White, ecity: W	
72 ho	Completed	(Speci	15. Decedent's E		1)	16a. Dece	dent's Usual Occu	pation during most o	ıf workina	16b. Kind	of Business/In	dustry
ges 1 and 2 should be filed within 72 ho tof Health and Mental Hygiene. If item 27 Is marked other then "nature or other treumatic event, ITEM MICAL	nple	Elementary/Secon			(1-4or 5+)	life.	DO NOT use retire	ad)	, working			
led w		12	First Middle 1 -			Wate	r Meter		None (Fine Aside)		imore	City
ntal H	Be	17. Father's Name (		()					Name (First, Middle		mame)	
should ind Men s marke umatic	င္	Joseph D  19a. Informant's Na		(Type Print)		19b Mail	na Addross /Stran		garet McMa or Rural Route Numb		um Stato Zir	Code
c, wall yearly 2.12. 1 end 2 should be filed within Health and Menial Hygiene. 1 marked other then there is the marked other them		Norman W		Brothe	r-in-				Dr., Lut	-		
Heal Heal		20a. Method of Disp		broche		20b. Place of Disp cemetery, cre			Date		ion - City or To	
ant of			ACremation 3 [ 5 ☐ Other (Spec					1	4-22-2005	Rol+	imoro	MD
permit. Pages 1 end 2 Department of Health a Important: If item 27 is any injury or other tre ance.		21 Signa fure of Fur			-	V 2	2. Name and Addr	ess of Facility	Ambrose F	uneral	Home,	Inc.
		W WW	1 and	1 W	DV4	0 1	328 Sulp	hur Spr	ing Rd.,	Arbatu	s, MD	21227
115		3a. Part1. Enter th	ne disease, or con 1 failure. List only	nplications that one cause on	caused the	ne death. Do not en	ter the mode of dyi	ing, such as ca	rdiac or respiratory a	arrest,		Approximate Interval Between
Physician		Immediate Cause ( disease or condition	Final		5	TROK	E					Onset and Death
/Medical Examiner		resulting in death)	-	Due to	o (or as a	consequence of):		1			To you and the	
LAGIIIIICI	_	Sequentially list con	nditions,	b. — Due t	1-14	PERT	ENSI	ON				
led	nine	cause. Enter Under Cause (Disease or	rlying	Due	7)		5 M		7110		-	
be executed ician and burial-transit	Examiner	that initiated events resulting in death) L	_	c. Due to	o (or as a	consequence of):	5 / 12		, ,			
cate be executed by sician and the burial-transit	dical			d.								
tificate ng phys as the	led									1		
w requires that the death certific been signed by the attending p should be detached for use as:	Physician/Med	23b. Was decedent		23c. If yes, o			⊒Ectopic pregnand	:y		23d.	Date of delive	<u>·</u>
e dea the at	sici	in the past 12 1 ☐ Yes 2 ☐ 9 ☐ Unknown		4 □ Pre- 9 □ Unk		me of death 5	Other (specify)				MONTH	Day Year
hat th d by i		Part II. Other signifi	icant conditions	contributing to	death hut	not resulting in the	inderlying cause gr	van in Part I	23e Did	tohacco use i	contribute to ti	he cause of death?
signe a be d	1 by	DEN	1 ENT	14	death but	not resulting in the	indenying cause gi	von in i diti.		Yes 2 A		pably 4 Unknown
read	etec			. , ,			···					
has ge 2	Completed								24a. Was		prior to co death?	psy findings available mpletion of cause of
vican The lavidate has rector, page 2	ပိ	25. Was case refer	red to medical	T				26 Place of	1 ☐ Yes f Death (Check only	2 12 No	1 🗆 Yes	2 No
ysicia s cert direct	0 8	examiner?		Hospital:	Inpatient	2 ER/Outpatie	nt 3 DOA Ot	hon	ing Home 5 ☐ Res		- lOther (Specif	v)
ng Phys ter this	n: T	27. Manner of Death	5 ☐ Pending	28a. Dat	e of Injury	Year) 28b. Time (	of 28c. Inju	And the second s	28d. Describe			
endir eath. or: Al	atle	2 Accident	investigation	00			M 1	]Yes 2□No	)			
To the Hospitel or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician properties in by the funeral director, page 2 should be detached for use as the	Certification:	3 Suicide 4 Homicide	6 Could not determine	286. Pla buil		y - At home, farm, si (Specify)			City or To	wn, State)		al Route Number,
Hosp 24 hol Fune stely fi	Medical	29a. Certifier (Check only one)	2 Medicel Exe	miner: On the	he best of basis of e anner state	xamination and/or in	th occurred at the to execution, in my	ime, date and p opinion, death	place, and due to the occurred at the time	cause(s) and date and pla	d manner as s ice, and due to	tated. the cause(s)
ro the vithin ro the comple	Me	29b. Signature and	title of certifier				29c. Licen	se number		29d. Date si	gned (Month,	Day, Year)
^		1/8	cyka	rau	~		10	2164	9	APRI.	L 20	2005
19		30. N., e and addre	SKAL	completed ca	use of dea	ath (Item 23a) (Type	Print)	NE	BALTIN	WE	MD 2	2005 -1229
Sta	- 1	31. Date filed (Mont	th, Day, Year)	32.	Registrar	's Signature	r					
Regist	1		APR	2 1 20	05	Marie 1	Local					
DHMH 17 Rev 1/2	:001					ORIGIN						

		mend Item#10e, p For Unpend Ite Registrar  1. Decedent's Name (First, Middle)	e, Last)				1	2. Date of De	ath C. I.	3. Time of Death
Physicia /Medic		Edgar Da	vis					April	7, 2005	2:36 P M
Examin	- 0	4a. Facility Name (If not institution	n, give street and number	er)	4	o. City, Town, or Lo	ocation of Deat	h	4c. County of	
		Northwest Regio				Randallst			Baltin	
uneral irector		5. Social Security Number 313-44-2232  Usual Residence of Decedent	6. Sex 7.	Age (In yrs. las 49			If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da 06/05	th y, Year) 5/55	9. Birthplace (State or Foreign Country) NY
Mo #		10a. State 10b. County		10c. City, 7	own or Locat	on				10d. Inside City Limits
a-f s	ctor	MD	Baltimore	:		Randalls <sup>.</sup>	town			1 ☐ Yes 2 ☐ No
3a or 28 at be no	al Director	10e. Street and Number 8608 8606 Bra	Bramble La Mble Lane	ane, Ap	t.103	10f. Zip Code 21133			10g. Citizen of Wh	nat Country? USA
ral', or items 23a or 28a-f show Examiner must be notified at	훈	11. Marital Status 1 ☐ Never Married 2[X Mar 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give	s? XNo	If Ye	Decedent of Hisp as, specify Cuban, Yes 2XNo	panic Origin? (S Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)		American Indian, White, etc. Black
han "natur e Modical	Completed by	(Specify only higher Elementary/Secondary (0-12)	t's Education st grade completed) College (1-40		6a. Decedent (Give kind life. DO Cha	's Usual Occupation of work done dur NOT use retired) uffeur	on ring most of wo	rking	16b. Kind of Busi	ness/Industry  Trucking
c event, In	Be	12 17. Father's Name (First, Middle,					8. Mother's Nar		Maiden Sumame)	
27 is mari	2	Francis G  19a. Informant's Name/Relations Leslie Davis /	ship (Type, Print)		19b. Mailing A	ddress (Street and 8608 Bra	Number or Ru amble L	ane Ranc	er, City or Town, Si lallstown	tate, Zip Code) MD 21133
Important: If Item 27 is marked other than "natural; any injury or other traumatic event, It a Musical Exagines.		20a. Method of Disposition  1  Burial 2  Cremation  4  Donation 5 Other (S	3 Anemoval from Sta	i cem	e of Disposition etery, cremate hill C	on (Name of ory or other place) emetery	4/13	Date /2005	20c. Location - C. Linder	
Importa any inju once.		21. Signature on Funeral Service	Licensee		Or or	ame and Address parles L. S 01 East Fo	tevens Fi	ineral Hom	e Inc.	
sician ledical		23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	a. Cocaine	line.	cation		such as cardiad	or respiratory a	rrest,	Approximate Interval Between Onset and Death
aminer	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b	as a consequer	ce of):					
physician and s the burial-transit	dical Exa	that initiated events resulting in death) Last	c Due to (or a	as a consequer	ce of);					
attending for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		2 Fetal de at time of deat	ath 3 ☐Ec	opic pregnancy her (specify)			23d. Date of Month	
signed d be d	b	Part II. Other significant condition	ons contributing to death	but not resultii	ng in the unde	tying cause given i	in Part I.	23e. Did to		ute to the cause of death?
certificate has been rector, page 2 shoul	Completed							24a. Was autop perfo 1 XYes	osy prio rmed? dea	ore autopsy findings available or to completion of cause of atth?  Yes 2 □ No
tor,	Be	25. Was case referred to medica examiner?					6. Place of Dea	th (Check only o	пе)	
96 96	n: To	1 X Yes 2 No  27. Manner of Death 1 Natural 5 Pendir 2 Accident investi		njury Day Year)	Outpatient b. Time of ound:	28c. Injury at Work?		ome 5 Resid	dence 6 Tother	- DCCIIC
After this uneral di	atlo	· ·	nined   286. Place of	njury - At home etc. (Specify)	, farm, street,	factory, office		28f. Location (S City or Tow Baltimo	Street and Number on, State 8607 re County	Rexfox Road , Maryland
irector: After this by the funeral di	Certificatio	3 ☐ Suicide 6 🛣 Could 4 ☐ Homicide determ	Found: h	ouse		_				
irector: After this by the funeral di	Jical Certification:	4 Homicide determ  29a. Certifier 1 Certifyir (Check only 2X) Medical	round: he page Physician: To the be Examiner: On the basis	st of my knowle of examination	dge, death oc and/or invest	curred at the time, igation, in my opini	date and place ion, death occu	, and due to the orred at the time,	cause(s) and mann date and place, and	er as stated. d due to the cause(s)
irector: After this by the funeral di	Medical Certificatio	4 Homicide determ	round: h	st of my knowle of examination	dge, death oc and/or invest	curred at the time, gation, in my opini	ion, death occu	rred at the time,	cause(s) and mann date and place, and 29d. Date signed (i	d due to the cause(s)
After this uneral di	Medical	4 Homicide determ  29a. Certifier (Check only one)  1 Certifyir 2 Medical	round: h	st of my knowle of examination stated.	and/or invest	29c. License no	ion, death occu umber	rred at the time,	date and place, and	d due to the cause(s)  Month, Day, Year)

			State of Maryland / Department of I			( ) ( ) ( ) ( ) ( ) ( )	10500
			1 - State Registrar Amend Item 2 per phy G842 Certificate of	Deatr4-21-	-05 tasee		3. Time of Death
	Physici		Avnetta Deshields		Month	45a 12-2005	6:45 KM
>	/Medic Examir		TIVIA ( C. )	or Location of Death	05 -	4c. County of Death	
			Ellicott City Health Howar	d		Columbia	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year 21 2 - 1 2 - 21 4.0 1 Months Days		8. Date of Birth (Month, Day,	Year) Count	ace (State or Foreign
	Director		212-12-2140 1 → 24 F 88 Yrs. World Says Usual Residence of Decedent		5-15-1	.916	
	yland		10a. State 10b. County 10c. City, Town or Location			10	Od. Inside City Limits
	e Mar in e-f si	ctor	Md Howard Columbia				1 ☐ Yes 2 X No
	or 28	<b>Funeral Director</b>	10e. Street and Number 10f. Zip Code		10	g. Citizen of What Count	ry?
	s 23e	eral	5230 Farm Pond Lane 2104	*	- Yes as No	U S A	on Indian
	fter de	Fune	Armed Forces? If Yes, specify Cub	Hispanic Origin? (Spe ban, Mexican, Puerto F	Rican, etc.)	Black, White, e	
9	hours after death with the Maryland tural', or Items 23a or 28a-f show at Exerciter cust be notified at	by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give 1 ☐ Yes 2 ☐ No	Specify:		Specify: Blac	2k
215-0036	72 hc	Completed	15. Decedent's Education 16a. Decedent's Usual Occu (Specify only highest grade completed) (Give kind of work done	during most of working	ng 1	6b. Kind of Business/Ind	ustry Unk
121	within lene. than "	idm	Elementary/Secondary (0-12)   College (1-4or 5+)   Beautician	ed)			
d 21	filed Hyg other	ပို	17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, M	aiden Sumame)	
Maryland		o Be	Edward DeShields	Belle R	Reason		
ary	a se se		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Stree	t and Number or Rura	l Route Number,	City or Town, State, Zip	Code)
	an n 2 n 2		Marlene Peters - Niece 5230 Farm Po		Columbia		
altimore,	iges 1 nt of H if iten or oth		20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)  20c. Place of Disposition (Name of cemetery, crematory or other place)	ace)	ate 2	0c. Location - City or Tov	vn, State
	permit. Pages Department of I Important: If ite any injury or of once.		'4 □ Dohation 5 □ Other (Specify) Arbutus Memorial  21. Signature of Funeral Service Aicensee 22. Name and Addr		Section (see the State of the S	Arbutus , Mo	i
Ba	Depart Impo		frome A Thompson	16.035 = 35	March F, ash Ave		, Md 21215
m	P 31		23a. Part   Enter the disease, or complications that caused the death. Do not enter the mode of dy shork or heart failure. List only one cause on each line.		The second secon	st.	Approximate Interval Between
	Physician		Immediate Cause (Final disease of condition Chronic Chronic	co Dulm	on cort	Discore	Onset and Death
	/Medical Examiner		Immediate Cause (Final disease of condition resulting in death)  a. Chronic ohshulus  Due to (or as a consequence of):  Athew Scientic Co	1	1	1) 10'	
в	Examiner	er		ercliovanc	war 1	Dixcase	
1	nsit		cause. Enter Underlying Cause (Disease or injury				
<u>,</u>	execu in and ial-tra	Examin	that initiated events c.  resulting in death) Last Due to (or as a consequence of):				
8/60,	icate be executed physician and s the burial-transit	edicai	d				
9	ertifica ing ph e as ti	Med	IF FEMALE:				
ROX	leath certifi attending   ifor use as	lan/	23b. Was decedent pregnant in the past 12 months?	у		23d. Date of deliver Month	y Day Year
o.	law requires that the death certif as been signed by the attending 2 should be detached for use as	Physician/M	1 ☐ Yes 2 MNo 4☐ Pregnant at time of death 5 ☐ Other (specify) _ 9 ☐ Unknown 9 ☐ Unknown				
, ק	res that igned by be deta	by Pr	Part II. Other significant conditions contributing to death but not resulting in the underlying cause gr	ven in Part I.	23e. Did toba	acco use contribute to the	cause of death?
rds	w require been sig should b				1 ☐ Yes	a 2 □ No 3 □ Proba	bly 4 Unknown
ecords,	faw re as be	Completed			24a. Was an autopsy	24b. Were autop	sy findings available ipletion of cause of
r	The lav	Соп			perform		
Vital	iclan: certifica rector, p	Be	25. Was case referred to medical examiner?  Hospital:	26. Place of Death	(Check only one,	)	
<u></u>	Phys r this ral dii	1: To	1 Inpatient 2 ENOutpatient 3 DOA	ursing Hon	ne 5 🗌 Residen 28d. Describe how	ce 6 Other (Specify)	
0	nding t tth. r: After e funer	atior	1 Natural 5 Pending (Month, Day Year) Injury Wo	ork? ]Yes 2∐No		, - ,	
DIVISION	al or Attending Physiclan: after death. I Director: After this certification by the funeral director.	Certification:	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	2	28f. Location (Stre City or Town,	et and Number or Rural State)	Route Number,
5	ital or irs afte ral Dir led in		, , , , , , , , , , , , , , , , , , , ,				
	To the Hospital of within 24 hours all To the Funeral D completely filled in	Medical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the ti 2 Medical Examiner: On the basis of examination and/or investigation, in my and manner stated.	ime, date and place, a opinion, death occurre	and due to the cau ed at the time, dat	ise(s) and manner as sta e and place, and due to	ted. the cause(s)
	o the	Mec	29h Signature and title of certifier 29c Licens	se number	290	d. Date signed (Month, D	ay, Year)
	- s - ō		> 5 Anne	30641	1	April 12	2005
	^		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	Nacio	P. 1	0 11	11. 12
	7		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Ramesh Sahapaihi 201-109 Back Riva  31. Date filed (Month, Day, Year)  APR 2 1 2005 Mesuse &	NIVECK	NOOCE	150 17 19 MOYC	1 (वापुविष्याय
	Sta Registi		31. Date filed (Month, Day, Year)  32. Registrar's Signature	16.1			
			APR 2 1 2005 Repease 15. April				

			For State Registrar	e of Maryland		artment of H rtificate of L			eg. No. 00	5	13521
	Physicia	an	Decedent's Name (First, Middle, Last)					2. Date of Dea Month	Day	Year	3. Time of Death
	/Medic		Daniel Henry Debel					April	20, 200		4:15A <sup>™</sup>
	Examin	er	4a. Facility Name (If not institution, give street an Gilchrist Center	d number)		TOWSC	Location of Death		4c. County o	timo	ro
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. I	ast birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		9. Birthp	lace (State or Foreign
	Funeral Director		217-12-5299 1XX 2	80	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day November	16,1924 I	Mary	Iand
	D .		Usual Residence of Decedent  10a, State 10b, County	10c City	. Town or Lo	nation					0d. Inside City Limits
	ehov ed al	ē									YYYes 2 No
	289-1	ect	Maryland N/A  10e. Street and Number	В	altimo	10f. Zip Code		1	0g. Citizen of W	hat Cour	
	3e or	Funeral Director	3939 ROland Avenue			2121	1	İ	USA		
	death	nera	44 Mariani Channa	Decedent Ever in U.s ed Forces?		Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (Spo	ecify Yes or No-		- Americ	an Indian,
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if item 27 is marked other than "natural", or items 23e or 28e-f ehow any figury or other traumatic event, the Midfall Examinant in the multillad at ponce.	by	1 Never Married 2 Married 1 Nover Married 1 Nover Married 2 Married 1 Nover Ma	Yes 2 No WW s, Give or Dates:	11	1 ☐ Yes 2 <b>X</b> ☐ No	Specify:	1110011, 010.7	Specify:		ite
5-0	72 hc	etec	15. Decedent's Education (Specify only highest grade comple	eted)	16a. Dece (Give	dent's Usual Occupa	ation during most of work	ing	16b. Kind of Bus	iness/In	dustry
21215-0036	within ene. than '	Completed	Elementary/Secondary (0-12) Collection 12	ege (1-4or 5+)	_	DO NOT use retired Ountant	)		Luml	oer	
<b>D</b>	illed Hygl other	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Name			)	
/Jar	Venta	To B	Wilbur Debelius				Rev	/a Smith			
Maryland	2 sho and is me		19a. Informant's Name/Relationship (Type, Print			ng Address (Street a					
e)	1 and 1ealth am 27 ther to		Mary Jo McClelland  20a. Method of Disposition	Dtr		Weston Av		cimore,	Marylano 20c. Location - C		
Jor	nt of h		1 ☐ Burial 2XX remation 3 ☐ Removal	from State	emetery, cre	matory or other place	θ)				
Baltimore,	artme ortani injury		2) Fignature of Funeral Service Licensee	ui ei		2 Name and Address					Maryland Home Inc.
ä	Dep imp any		Jennis & Jesken	Hanak	Ex .				timore, M		
П			23a. Part1. Enter the disease, or complications shock, or heart failure. List only one cause	that caused the death on each line.	1	, ,	-		est,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	Dro		rte C.	Ancer				Jeans
	/Medical Examiner		Du Du	ie to (br as a consequ	uence of):						0
		Jer		ie to (or as a consequ	uence of):					-	
V	cuted nd ransit	Examiner	Cause (Disease or injury that initiated events c								
90,	icate be executed physician and s the burial-transit	I Ex	resulting in death) Last Du	ue to (or as a consequ	uence of):						
<b>58760</b> ,		edicai	d								
Box (	leath certific attending pl			s, outcome of pregna		Je.,			23d. Date	of delive	ery
œ.	es that the death cenigned by the attendin be detached for use	Physician/M	in the past 12 months?	Live birth 2□Fetal Pregnant at time of de Unknown		□Ectopic pregnancy □ Other (s <i>pecify)</i>			Mon	th	Day Year
P.O.	at the	Phy	9 ☐ Unknown  Part II. Other significant conditions contributing		ulting in the c	andorh ing souso gra	on in Port I	23e Did to	bacca usa cantri	hute to th	ne cause of death?
Records,	The law requires that the death certif te has been signed by the attending tage 2 should be detached for use a	d by	Part II. Other signmeant conditions continuum	g to death but not rest	in the t	инденуяну сацье дил	en in Fait i.				ably 4 Unknown
500	w requires been si	Completed						24a. Was a	n 24b. W	ere auto	psy findings available
	The lav	шо						autop: perfor	med?   de	ath?	mpletion of cause of 2 No
Vital	ysician: The is certificate hadirector, page	Be C	25. Was case referred to medical examiner?				26. Place of Deat		/~		
of V	Physician: r this certific ral director,	은	1 ☐ Yes 2 No Hospital:		ER/Outpatie		4   Nursing no	me 5 Resid			Hospice
nc	fter	ilon:	1 Natural 5 Pending	Date of Injury (Month, Day Year)	28b. Time o	Worl	/ at <br Yes 2 □ No	28d. Describe h	ow injury occurre	d	
Division	Attending of death.	ficat	2 Accident investigation 3 Suicide 6 Could not be determined 28e.	Place of Injury - At ho	me, farm, st				treet and Numbe	r or Rura	l Route Number,
Ö	s after s after al Dire	Certification;	4 Homicide	building, etc." (Specif)	()			City or Tow	n, State)		
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the tu	edical (	29a. Certifier (Check only one) 1 Certifying Physician: 2 Medicel Examiner: On and	To the best of my kno the basis of examina manner stated.	wledge, deat tion and/or in	th occurred at the tin evestigation, in my o	ne, date and place, pinion, death occurr	and due to the cred at the time, c	ause(s) and man late and place, a	ner as s	tated. o the cause(s)
	To the To the comp	Me	29b. Signature and title of certifier	10		29c. Licenso			9d. Date signed		
)			6/1 Hothers	Kly	, cus	0 12	5205		April.	20,	2007
	lo				23a) (Type,	Print) M. Cha	5205 les St. 1	Balto.	md 21	20)	k.
	Sta		31. Date filed (Month, Day, Year)	32. Pigistrar's Signa	ture	1					
	Registi	rar	APR 2 1 2005	person.	D A	2848					

EBELIUS ,

		,	1 - State of Maryland / Dep Registrar  Ce	artment of Health and Nertificate of Death		ene g. No. 2005   3522
2	Physicia /Medic		1. Decedent's Name (First, Middle, Last)  James Despeaux Dent		2. Date of Death Month AFRI	Day Year
ı	Examin		4a. Facility Name (If not institution, give street and number) Saint Joseph Medical Center	4b. City, Town, or Location of Death	on	4c. County of Death Baltimore
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 212-20-0666 XX 2 F 80 Yrs.	If Under 1 Year   If Under 24 Hrs.   Months   Days   Hours   Min.	8. Date of Birth (Month, Day, 1	9. Birthplace (State or Foreign Country) 924 Mary Land
	aryland show	_	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or L			10d. Inside City Limits
	h the Ma r 28a-f	irecto	Maryland Baltimore Balt  10e. Street and Number	imore 10f. Zip Code	10	1 □ Yes 2 → No g. Citizen of What Country?
	ath wit	raiD	4 Murdock Road	21212		U.S.A.
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itams 23a or 28a-f show any injury or other traumatic event. It is Modical Examinate to with the Judical and Once.	by Funeral Director	11. Marital Status  1	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto  1 ☐ Yes 2 ☑ No Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: White
Maryland 21215-0036	in 72 hou n "nature Wediest E	Completed	(Specify only highest grade completed) (Give	edent's Usual Occupation e kind of work done during most of work DO NOT use retired)	ing	6b. Kind of Business/Industry
2	ed with ygiene ner the	Com	12 Acc	count	(F) . A (1) . I .	Lumber
/land	uld be fill Mental H srked oth	To Be	17. Father's Name (First, Middle, Last) UNKNOWN	Unknown	e (First, Middle, Ma	
Man	id 2 sho lth and 27 la ma trauma			ing Address <i>(Street and Number or Rur</i> rdock Road Baltimo		
	es 1 an of Heal fitam 2 rother					Oc. Location - City or Town, State
Baltimore,	it. Pag intment intent: I injury o		`4 □ Donation 5 □ Other (Specify) Greenmous	nt Crematory 4/21	the state of the s	Baltimore,Maryland
Ba Ba	Depar Impo any ir		Dennis Alesken Kenakes	Name and Address of Facility Mitchell—Wiedefel 6500 York Road B	d F.H. In altimore	
8760, <	Medical Examiner  /Medical Examiner  the burial-fransit	il Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not enshock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):	iter the mode of dying, such as cardiac	or respiratory arres	st, Approximate Interval Between Onset and Death
.O. Box 6	death certific e attending p ed for use as	Physician/Medical		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
ecords, P	Se Pg	by	Part II. Other significant conditions contributing to death but not resulting in the MYELODYSPLASIA	underlying cause given in Part I.	23e. Did toba	acco use contribute to the cause of death?  S 2 No 3 Probably 4 Unknown
$\mathbf{\alpha}$	The ate h	Completed			24a. Was an autopsy perform 1 Yes 2	prior to completion of cause of
Vital	Physician: Th r this certificate ral director, pa	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 No  Hospital: 1 Inpatient 2 ☐ ER/Outpatie	Other	h (Check only one	nce 6 Other (Specify)
on of	ing After	<del> -</del>	27. Manner of Death  1 Natural 5 Pending (Month, Day Year) 2 Accident investigation		28d. Describe how	
Division	of Attending after death. Director: After d in by the fune	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (Stre City or Town,	eet and Number or Rural Route Number, State)
	Hospite 4 hours Funeral	edical C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, deal (Check only one)  1 Medical Examiner: On the basis of examination and/or in and manner stated.			
	To the within 2 To the complet	Me	29b. Signature and title of Certifier	29c. License number D 37254		d. Date signed (Month, Day, Year)
	1.		30. Name and address of person who completed cause of death (Item 23a) (Type			4. (1
	✓ Sta	ate	31. Date filed (Month, Day, Year) 32. Recentrar's Signature	IVE TOWSON MARY	LAND 21	204
	Regist		APR 2 1 2005	South .		

DHMH 17 Rev 1/2001

ORIGINAL

	1- State of Maryland / Department of Health and I Certificate of Death	Mental Hygiene 005 13523
Physician	Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year  3. Time of Death
/Medical	SONYA ERRAJRAJI	April 18 2005 0509AM
Examiner	4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death UNION MEMORIAL HOSPITAL  BALTIMORE	h 4c. County of Death N/A
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth 9. Birthplace (State or Foreign
Director	213 86 7698 1 M 2 F 33 Yrs. Months Days Hours Min.	JAN. 28, 1972 MARYLAND
A w	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
Maryla 1 aho 1 aho		1 TYYes 2 □ No
with the Mar t or 28a-f al the notified	10e. Street and Number 10f. Zip Code	10g. Citizen of What Country?
	4200 LOCH RAVEN BLVD 21218	U.S.A.
of iter death viriter death viritems 234	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert	pecify Yes or No- lo Rican, etc.) 14. Race - American Indian, Black, White, etc.
urs afte	1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No If Yes, Give 1 ☐ Yes 2 ☑ No Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates:	Specify: BLACK
2 hours	15. Decedent's Education 16a. Decedent's Usual Occupation	16b. Kind of Business/Industry
ed within 72 hor vgiene.  Get than "natura", the wedcall Completed	(Specify only highest grade completed) (Give kind of work done during most of work life. DO NOT use retired)  Elementary/Secondary (0-12) College (1-4or 5+)	rking
Sorth Corr	9th MORTGAGE CONSULTANT	MORTGAGE COMPANY
tal Hy doth event	HEDDERT COLEMAN CANDRA D	ne (First, Middle, Maiden Sumame) RETT
Id yidiid Ziz		ural Route Number, City or Town, State, Zip Code)
IVIA Id 2 s Id an It au	STACEY BELL (COUSIN)  3600 BONVIEW AVE. BALT	, , , , , , , , , , , , , , , , , , , ,
parmit. Pages 1 and 3 bepartment of Health Important: If item 27 anyinjury or other tr. once.	20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)	Date 20c. Location - City or Town, State
Deficiency bernit. Pages Deportment of mportant: If it iny injury or o	1 Burial 2 Cremation 3 Hemoval from State	L 20, 2005 BALTIMORE, MARYLAND
Dollar permit. Deportm Importa any inju	CREEK LOCKE CHEEK LECKE LEE	LVIN B. SCRUGGS FUNERAL HOME
0 88E88	Decoratione // Cruney 1412 E. PRESTON STR	KEET BALTIMORE, MARYLAND 21213
WY B	23a. Part1. Enter the disease, or complications that caused the leat. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.	Interval Between
Physician	Immediate Cause (Final disease or condition a. H1V / A1DC	Onset and Death  3 Vecurs
/Medical Examiner	resulting in death)  Due to (or as a consequence of):	
	Sequentially list conditions, b. Pocumonia	in Days
executed in and ial-transit	Tany, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	25 Days
an an rial-tr	resulting in death) Last Due to or as a consequence of):	23 =129 3
cate be executed physician and the burial-transit	d	
box occidence the state of the	IF FEMALE:	( )
The law requires that the death certific the law requires that the death certific ate has been signed by the attending page 2 should be detached for use as completed by Physician/Mer.	23b. Was decedent pregnant in the past 12 months?  4 Pregnant at time of death 5 Other (specify)	23d. Date of delivery  Month Day Year
the de ched	1 Tes 2 No 9 Sunknown	
es that igned by be deta	Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?
wrequires that we require strat s been signed to should be dett		1 Yes 2 No 3 Probably 4 Unknown
The law requir cate has been s page 2 should		24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of
The The page		performed? death?  1 Yes 2 1 No 1 Yes 2 1 No
ician: Tician: Tician: Betor, pr	eyaminer/	ath (Check only one)
Physic rithis corral direction of the correction		dome 5 ☐ Residence 6 ☐ Other (Specify)
After funer funer	27. Manner of Death  28a. Date of Injury  (Month, Day Year)  28b. Time of 28c. Injury at Injury  1 □ Accident investigation  M 1 □ Yes 2 □ No	28d. Describe how injury occurred
i or Attending after death. Director: Attellin by the fune	2 Accident investigation  Suicide 6 Could not be determined determined  28e. Place of Injury - At home, farm, street, factory, office	28f. Location (Street and Number or Rural Route Number,
tal or Attending P rs after death. al Director: After ted in by the funers Certification:	4 Homicide building, etc. (Specify)	City or Town, State)
		, and due to the cause(s) and manner as stated.
the Hosp in 24 hou the Fune apletely fill		
To t To t	29b. Signalure and title of certifier  Jecely ne Kouetchou, MJ  29c. License number  AT243894	29d. Date signed (Month, Day, Year)
9	71243614	7 77 70 2005
3	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  JOCELYNE ILOUATCHOU ZOIEAST University  Po	6 April 18 2005 wewey Ballimore MJ 21218
State	31. Date filed (Month, Day, Year) 32. Registrar's Signature	
Registrar	APR 2 1 2005	

Darlene A. Elliot 05-22

DOS

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

299	)		State of Maryland / [ 1- State Registrar		artment rtificate			nd M		iene2 ()	05	13	521
	Dhusisi		Decedent's Name (First, Middle, Last)						2. Date of Deat Month	h Day	Year	3. Time	of Death
	Physici /Medio		Darlene Elliott						April :			0936	a <sup>M</sup>
	Examir	ner	4a. Facility Name (If not institution, give street and number)				Location of	Death	4c. County of Death				
			51 Glen Ridge Court C4		Glen		nie If Under 2	A Hre	0.0	Anne A			
	Funeral Director		5. Social Security Number 6. Sex 7. Age ⟨In yrs. last bit 1	Yrs.	Months	Days	Hours	Min.	8. Date of Birth (Month, Day, July 16	Year)	9. Birth Cou	place (State intry)	or Foreign
			Usual Residence of Decedent						July 10	, 1949	Hal	yland	
	yland		10a. State 10b. County 10c. City, Tow									10d. Inside	City Limits
	e Ma	ctol	MD Anne Arundel G	len	Burn	Le						1 🗆 Ye	s 2X No
	ith th	by Funeral Director	10e. Street and Number		10f. Zip	Code			10	0g. Citizen of \	What Cou	intry?	
	s 23a	ral	51 Glen Ridge Court #C				21061			US			
	er de Items	nne	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?	13. \	Was Decede f Yes, spec	ent of Hi fy Cubai	spanic Orig n, Mexican,	in? (Spe Puerto l	cify Yes or No- Rican, etc.)		e - Ameri k, White	ican Indian, , etc.	
36	rs aft	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		1 ☐ Yes 2	X No	Specify:			Specify	· w.	hite	
Maryland 21215-0036	within 72 hours after deeth with the Maryland ene. Than "natural" or Items 23a or 28a-f show he Madical Examiner must be notified at	ted	15. Decedent's Education 16a.	. Decer	dent's Usua	Occupa	ition			16b, Kind of B	usiness/lr	ndustry	
212	hin 7.	ple	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	(Give life. l	kind of wor DO NOT us	k done d e retired)	uring most	of workir	ng				
7	ed wil	Completed	unk unk		house	keer	ing			dep	t_st	ores	
2	be file	Be	17. Father's Name (First, Middle, Last)				18. Mother	's Name	(First, Middle, N	Maiden Suman	ne)		unk
<del>Z</del> a	ould Men Marke	2	Joseph Parks										
Mar	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  Say injury or other traumatic event, the Medical Examiner must be notified at once.								l Route Number,	ACTION CON		p Code)	
e,	1 and Healtl em 2		Anthony Nickalo/son in law 3:  20a. Method of Disposition 20b. Place of				Road (		Burnie	MD 2 20c. Location -		own State	
و	Pages nent of I int: If its iry or of		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State cemeter	ry, cren	natory or ot	her place	9)		4.0	LOC. LOCATION	City of 1	OWII, State	
Baltimore,	ii. Pa		'4 □Donation 5 🖾 Other (Specify) In State	20	Namo and	1 Addros	a of English		-				
Ba	Depa Impo any ii	6 4	21. Signatur Funeral Service Licensee Run 11d S. Wade Director	Si Ba	tate A altimo	natore,	omy Bo	oard 2120	655 W.	Baltim	ore	Street	t
	'nysician /Medical Examiner	(O )	23a. Pan 1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequent of the condition  of the condition of the conditio									Approxima Interval 8a Onset and	etween
,092	rate be executed thysician and the burial-transit	Ical Examiner	Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence c. Due to (or as a consequence d.										
.O. Box 68	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 Unknown  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown		Ectopic pre					23d. Dat Mo	e of deliv	ery Day	Year
ds, P	signed det	by	Part II. Other significent conditions contributing to death but not resulting in	n the ur	nderlying ca	use give	n in Part I.		23e. Did tob	acco use conti s 2₩No		the cause of bably 4	
Ö	w requir been si should	ete							24a. Was ar				
~	: The lay cate has	Completed							autopsy	red?		opsy finding ompletion of 2 No	
	ilcian: Th certificate rector, pag	Be	25. Was case referred to medical examiner?  1 Types 20 Ne Hospital:			Othe			(Check only one				
ō	Phys r this ral dii	. To	27. Manner of Death 28a. Date of Injury 28b.	utpatien Time of		A Injury	" 4 □ Nur:	sing Hon	ne 5 Reside 8d. Describe ho	nce 64 Oth	er <i>(Speci</i> ed	(fy) at s	cene
on .	ding h. After funer	tlon	1 Natural 5 Pending For Month, Day Year)	Iniviry	L M	lc. Injury Work	? ′es 2.2XiN		5 Do yea	t 51-01	se	6	
Visi	l or Attending Physician: after death. Director: After this certifics in by the funeral director. (	Certification:	2 Accident  3 Suicide 4 Homicide    Accident   Accident						8f. Location (Str City or Town	eet and Numb	er or Rur		mber,
ā	ospital or A hours after uneral Dire ly filled in b	Cerl		on	e			-	51 Glen		BUN	rie)	MD.
	I 4 I 0	edical	29a. Certifier (Check only (Ch	e, death	occurred a	t the tim in my op	e, date and inion, death	place, a	nd due to the ca	use(s) and ma	nner as s	stated. o the cause	(s)
	To the H within 24 To the Fi complete	Med	one) and manner stated.  29b. Signature and title of certifier		29c	License	number		20	d. Date signed	(Month	Day. Year	
	F ≥ F 8		Lashar Greense M	D		OCN				pril 2			
			30. Name and address of person who completed cause of death (Item 23a)	(Tues	Print\	J 01.					,,		
			Tasha Z Greenberg M.D.	(туре,		Per	n Str	eet	Baltim	ore. Ma	arv1s	and 21	2.01
	Sta	te	31. Date filed (Month. Day, Year) 32. Registrat's Signature	-			501		اللبدن بدين	ULC 9 116	+ <b>-</b> у л с	u 21	201
	Registi		APR 2 1 2005 Days 15	60	and I								

State

Registrar

31. Date filed (Month, Day, Year)

111 Penn Street

Baltimore, Maryland 21201

M.D

2005

32. Redistrar's Signature

			For	State of Ma	ıryland			Health a	and Me	•	iene	The late of the same
			1 - For State Registrar  1. Decedent's Name (First, Middle, La	oth		Cei	tificate of	Death		Re 2. Date of Deat	g. No.	3526
	Physicia		1. Decedent's Name (First, Middle, La	Charles	s For	rd				Month Dril 17	Day Ye	ar 3. Time of Death 11:30A M
	/Medic Examin		4a. Facility Name (If not institution, giv	e street and number)			4b. City, Town,	or Location of		pili i	4c. County of	
			Home; 3505 Roland					ltimor	N/A			
	Funeral Director		5. Social Security Number 6. S 220–20–2136	Sex 7.Age √[3]:M 2 □ F		st birthday) Yrs.	If Under 1 Year Months Days		Min.	3. Date of Birth (Month, Day,	rear)	Birthplace (State or Foreign Country)
	D		Usual Residence of Decedent		76				J	une 26,	1928   [	laryland
	arylar show	7	10a. State 10b. County	N/A	10c. City,	Town or Lo	<sub>cation</sub> Baltimore	2				10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	the M	recto	Maryland  10e. Street and Number	1/ A			10f. Zip Code	<del></del>		10	og. Citizen of Wha	
	h with	al Di	3505 Roland Avenu	ie				1211				USA
	lams	ner	11. Marital Status	12. Was Decedent E Armed Forces?		13. 1	Was Decedent of f Yes, specify Cul	Hispanic Ori can, Mexican	gin? (Speci	ify Yes or No- ican, etc.)		American Indian, White, etc.
36	within 72 hours after death with the Maryland ene. than "natural", or itams 23e or 28a-f show the Mcdital Examiner must be notified at	by Funeral Director	1 ☐ Never Married 2 ☐ Married  3√☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2/XN If Yes, Give Year or Dates:	0		1□Yes XIX No	Specify:			Specify:	white
9-0	72 hou	ted	15. Decedent's Education (Specify only highest gra	ducation		16a. Deced	ient's Usual Occu	pation	t of working	. 1	16b. Kind of Busin	ess/Industry
21	within 7	Completed	Elementary/Secondary (0-12)	College (1-4or 5-	+)		kind of work done DO NOT use retire	ed)	t or working	<b>'</b>	0 0	
d 2	filed v Hygie ther t		12 17. Father's Name (First, Middle, Last,	)		IMa	chinist	18. Mothe	er's Name (	First, Middle, N	Can Con	ipany
Maryland 21215-0036	Mental Mental rked o	To Be	Herbert C. For	:d						e Sherf		
lary	2 should have and have is man		19a. Informant's Name/Relationship (				-		_		City or Town, Sta	
e,	1 and fealth sm 27 thar tr		Stephen Carle  20a. Method of Disposition	Nephew	20h Pla		lammersha		Ta		ı, Maryla 20c. Location - Cit	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itams 23a or 28a-f show any Injury or othar traumatic event, it e Medical Examiner must be notified at once.		1 XX xurial 2 □ Cremation 3 □ '4 □ Donation _5 □ Other (Specif				sition (Name of natory or other pla Park Cer					, Maryland
altir	mit. F partme sortan / Injur		21. Signatur of Funeral Service Light		1							
<u>~</u>	Depa Impo any ir	, i	Stary	larpu	tu	عام 36	31 Falls	s Road	Bal	uneral timore,	Home, In Marylan	d 21211
r			23a Part1. Enter the disease or com shock, or heart failure List only						cardiac or	respiratory arre	est,	Approximate Interval Between Onset and Death
	Pnysician - /Medical	1	Immediate Cause (Final disease or condition resulting in death)	aMA1			MELAN.	AMO				
E.	Examiner		Conventinity link one distance	b.	conseque	orice orj.						
	sit ad	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a	conseque	ence of):						
	xecute and al-tran	Examiner	that initiated events resulting in death) Last	c Due to (or as a	conseque	ence of):						
3760,	death certificate be executed to attending physician and for use as the burial-transit	cal		_ d								
3	entifica ling ph e as th		IF FEMALE:									
Вох	eath certific attending p	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at t	2 □ Fetal d	death 3	Ectopic pregnand Other (specify)	су			23d. Date of Month	f delivery Day Year
P.O.	t the d	hysi	1 ☐ Yes 2 DNo 9 ☐ Unknown	9□ Unknown			, Othor (Speedily) _					
	The law requires that the de ate has been signed by the a page 2 should be detached t	by	Part II. Other significant conditions of		t not result	ting in the u	nderlying cause g	ven in Part I.			\/	te to the cause of death?
ord	w requir been si should	eted	SEIZURE AL	is mark						1 Tye		Probably 4 Unknown
Records,	he law s has b	Completed								24a. Was an autopsy perform	ried? prior deat	
ta	an: T	O	25. Was case referred to medical					26. Place	of Death (	1 ☐ Yes 2 Check only one	1 🗆	Yes 225No
of Vital	hysici his cer I direc	To B	examiner? 1 Yes 2	Hospital: 1 Inpatien			t 3 DOA	her: 4□Nu			nce 6 Other (	Specify)
o uc	ding Physician: The In.  After this certificate he funeral director, page		27. Manner of Death 1	28a. Date of Injury (Month, Day	Year) 2	28b. Time of Injury	28c. Inju Wo	ıry at ork? ]Yes 2 □ I	28		w injury occurred	
Division	i or Attending Physician: after death. Director: After this certifica i in by the funeral director.	ficat	2 Accident Investigation 3 Suicide 6 Could not b	e 28e. Place of Inju-	ry - At hom	ne, farm, str						r Rural Route Number,
Ö	i de i	Certification;	4 Homicide	building, etc.	. (Specify)					City or Town,	State)	
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical	29a. Certifier (Check only one) I Certifying Ph	nysician: To the best of niner: On the basis of and manner stat	examinatio	ledge, death on and/or inv	occurred at the trestigation, in my	ime, date an opinion, deat	d place, an th occurred	d due to the car l at the time, da	use(s) and manne te and place, and	or as stated. due to the cause(s)
	To the To the comp	M	29b. Signature and title of certifier					se number			d. Date signed (N	1
	i		· Kum	MD.			05	1715			4/19	9/05
	Ų		30. Name and address of person who	completed cause of de	71	23a) (Type,	3730	FA	us k	u.Avs	BALTIMO	9 1 °S NE MA 2/21)
	Sta Registr		31. Date filed (Month, Day, Year)	32. Regular	r's Signatu	T.	pare					

			4 101	artment of Health and Mental Hyg	75) 6th - 170 - 1704
			Decedent's Name (First, Middle, Last)	2. Date of Dea	Reg. No. 3. Time of Death
	Physic /Medi		Elsie Minerva Feidt	Month April	18, 2005 Year 3:15 A M
	Exami		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
			Lorien - Bel Air	Bel Air	Harford
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Months Days Hours Min. (Month, Day	y, Year) Country)
	Director		Usual Residence of Decedent	June 1	3, 1923 Pennsylvania
	iand		10a. State 10b. County 10c. City, Town or Lo	ocation	10d. Inside City Limits
	Mar)	ţō	Maryland Harford Hayre	de Grace	1 Yes 2 □ No
	in the	Director	10e. Street and Number		10g. Citizen of What Country?
	23a (	alD	308 Miller Court	21078	USA
	r dea	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Armed Forces?	Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
36	s afte , or H	by Fu	1 Never Married 2 Married 1 Yes 2 No If Yes, Give	1 ☐ Yes 2√☐ No Specify:	Specify: White
21215-0036	within 72 hours after death with the Maryland ane. than "natural", or itema 23a or 28a-f show he Madical Exercise must be invitited at	ed b	Teal of Dates.	dent's Usual Occupation	MILEC
15	n "na	Completed	(Specify only highest grade completed) (Give	beind of work done during most of working DO NOT use retired)	16b. Kind of Business/Industry
212	d with	E	Elementary/Secondary (0-12) College (1-4or 5+)  8 Fact	ory Worker	Shoe Manufacturer
	be filed within 72 hours after death with the Marylar Ital Hygiene. Id other than "natural", or flema 23a or 28a-f show of other than "natural", or flema 23a or 28a-f show event, the Madical Examilizer must be undifficed at	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle,	
Vai	2 should be filed withir and Mental Hygiene. is marked other than sumatic event, the M	70 6	Jacob M. Wolfe	Mary E. Harne	
Maryland	2 shd and is m			ing Address (Street and Number or Rural Route Numbe	
	ges 1 and 2 should it of Health and Mer if item 27 is marke or other traumatic			Miller Court, Havre de (	· · · · · · · · · · · · · · · · · · ·
Ö	Pages 1 nent of H int: if ite		I Labouriai 2   Cremation 3 2   Hemoval from State	matory or other place)	20c. Location - City or Town, State
Baltimore,	it. Pa rtmer rtant njury				Elizabethville, PA
Ba	permit. Pages 1 and 2 Department of Health a Important: if item 27 is any injury or other tra once.		May la la base	Name and Address of Facility McComas Funeral Home, P. A	
			23a. Part1. Enter the disease, or complications that salsed the peath. Do not enishook, or heart failure. List only one cause on each line	1317 Cokesbury Road, Abing ter the mode of dying, such as cardiac or respiratory are	gdon, MD 21009  Rest, Approximate
	Physician		Immediate Cause (Final		Interval Between Onset and Death
7	/Medical		disease or condition resulting in death)  a. UNIVI(1)  Que to (or as a consequence of):	MISPAC	
	Examiner		Sequentially list conditions b. Chip lowy, many		
	₽ #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		
	ecute and trans	Examiner	that initiated events c.		
8760,	sician and burial-transit	E	Due to (of as a consequence of):		
387	ate hy the	dical	d. When the ha		
9 xc	eath certific attending p for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy		23d. Date of delivery
Box	death atter	clar	in the past 12 months? 1 Live birth 2 Lifetal death 3L	□Ectopic pregnancy □ Other (specify)	Month Day Year
0	at the de by the tached	hys	9 Unknown		
٦,	es tha Igned I be det		Part Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I. 23e. Did to	bacco use contribute to the cause of death?
ord	w require been slo should t	Completed by	allow of the british biseld	<u>₩</u> 1□Y	es 2 No 3 Probably 4 Denknown
ec.	e lawr has be je 2 sh	ple		24a. Was a autops	
R		Con		perform	
Vital Records,	sicien; Th certificate irector, pag	Be	25. Was case referred to medical examiner?	26. Place of Death (Check only or	
of	this al din	2	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatier		T a war so or
n	E E	lon	27. Manger of Death  1	f 28c. Injury at 28d. Describe how Work?  M 1 ☐ Yes 2 ☐ No	ow injury occurred LIVING
Division	Attendideath. ctor: A y the fu	lical	2 Accident investigation 3 Suicide 6 Could not be determined elemented.		treet and Number or Rural Route Number,
Div	after after Dire	Certification:	4 Homicide determined building, etc. (Specify)	City or Town	n, State)
	To the Hospital or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funer		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death	h occurred at the time, date and place, and due to the c	ause(s) and manner as stated.
	he Ho in 24 he Fu pletel	Medical	(Check only ane)  2 Medical Examiner: On the basis of examination and/or in and manner stated.	vestigation, in my opinion, death occurred at the time, d	late and place, and due to the cause(s)
	To the Hospital or Attendit within 24 hours after death. To the Funerel Director: Al compleiely filled in by the fu	Σ	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	Y		P 11 94 7/17	14041	4/18/05
ĺ	D		70. Name and address of berson who completed cause of death (Item 23a) (Type,		4078
	Sta	te	31. Date filed (Month, Day, Year) 32 Registrar's Signature	1400	1.10
	Registr		APR 2 1 2005 64 4	2000	

Physici		1. Decedent's Name (First, Middle, L	n #12,17,181	9a&b&20a=	C AZZ G84	IZ JH	2. Date of Death		3. Time of Death
/Medio		George Edward F	oster				April	6, 2005 Ye	11:50 AN
Examir		4a. Facility Name (If not institution, g			4b. City, Town, or		1	4c. County of I	
		Potomac Valley			Rockv	rille If Under 24 Hrs.	0.0000		omgery
Funeral Director		5. Social Security Number 6. 578-52-3543  Usual Residence of Decedent	**	In yrs. last birthday) 65 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Jan 31,	1940 V	Birthplace (State or Fore Country) irginia
ryland how		10a. State 10b. County		Oc. City, Town or Lo					10d. Inside City Lim
8a-1s	ctol	MD Montgo	nery	Rockv					1 ☐ Yes 2 <b>次</b> I
with the	Dire	10e. Street and Number 1235 Potomac Va	allow Dood		10f. Zip Code	20050	10	g. Citizen of Wha	at Country?
ns 23	eral	11. Marital Status	12. Was Decedent Eve	er in U.S. 13.	Was Decedent of Hi	20850 spanic Origin? (S	pecify Yes or No-	USA 14. Race -	American Indian,
urs after o al', or itan	by Fun	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces?	1	Was Decedent of Hi If Yes, specify Cuba 1 □ Yes 2∑ No	n, Mexican, Puert Specify:	o Rićan, etc.)	Black, \ Specify:	White, etc. black
s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Ifam 27 is marked other than "natural, or itams 23e or 28e-f show other traumatic event, the Medical Exactly and market traumatic event, the Medical Exactly and recognitional terms.	Completed by Funeral Director	15. Decedent's (Specify only highest of Elementary/Secondary (0-12)	Education trade completed)  College (1-4or 5+)	16a. Dece (Give life.	dent's Usual Occupa kind of work done o DO NOT use retired	ation furing most of wor )	king	6b. Kind of Busin	ess/Industry
ed wit ygiene yar tha	Con	unk 12th	unk		manag				food bank
2 should ba filed within 7 n and Mental Hygiene. Fis marked other than "raumatic svant, I'le Med	Be	17. Father's Name (First, Middle, La	st)		unk		ne (First, Middle, M	,	U
should nd Mei marke matic	2	EDDTE SHORT  19a. Informant's Name/Relationship	(Typa, Print)	19b. Mailir	ng Address (Street a		AN FOSTEI		ite Zin Code)
and 2 sauth ar n 27 is iar trau		19a Informant's Name/Relationship SHIRLEY ANN FOST Sharon Foster/d	ER/WIFE aughter	3401	ng Address <i>(Street a</i> Dodge Pa	T-3	Hvattevil	10 MT)	20785
permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr 90ce.		20a. Method of Disposition  Burial 2 Cremation 3  4 Donation 5 Mother (Spec	☐Removal from State	20b. Place of Dispo	sition (Name of matory or other plac		Date 2	0c. Location - City	y or Town, State
permit. Pages Department of Important: If if any injury or c		21. Signature of Euneral Servic Lice RO 1 Ld		. 22	2. Name and Address tate Anato	s of Facility J. B	JENKINS	LANDOVER FUNERAL NDOVER	HOME D. STANDOVER
/Medical Examiner up price on the price of t	Physiclan/Medical Examiner	disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a control of the to (or a) control of the to (or a) control of the to (or a) control	ONIA					
2 > 2	led	`	d.						
the death cartifical y the attending phi tched for usa as th	nysiclan/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 □Live birth 2 [ 4 □ Pregnant at tim 9 □ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of Month	f delivery Day Year
quires that the death cartifical n signed by the attending phi uld be detached for usa as th	by	23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown  Part II. Other significant conditions	1 ⊡Live birth 2 [ 4 □ Pregnant at tirr 9 □ Unknown	Fetal death 3 [ne of death 5 [	Other (specify)	on in Part I.	23e. Did toba 1 □ Yes	Month	•
The law requires that the death cartific ste has baen signed by the attending p page 2 should be detached for usa as	by	23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown  Part II. Other significant conditions	1 Dive birth 2 ( 4 Pregnant at tire 9 Unknown  contributing to death but r	Fetal death 3 ne of death 5 not resulting in the un	Other (specify)	en in Part I.	1 ☐ Yes 24a. Was an autopsy perform	Month acco use contribut s 2√No 3 [	Day Year  te to the cause of death?  Probably 4 Unknov e autopsy findings availat to completion of cause of
The law requires that the death carrific ste has baen signed by the attending p page 2 should be detached for usa as	Be Completed by	23b. Was decedent pregnant in the past 12 months?  1   Yes 2   No 9   Unknown  Part II. Other significant conditions  DIABETES A  CEREBROVASCU  25. Was case referred to medical examiner?	1 Dive birth 2 ( 4 Pregnant at tirr 9 Unknown  contributing to death but r  MELLITUS  ULAR DISE	□ Fetal death 3 □ ne of death 5 □ not resulting in the un	Other (specify)	26. Place of Dea	1 Yes  24a. Was an autopsy perform 1 Yes 2*	Month acco use contributes 2√No 3 [ 24b. Wern prior deat   Anno 1 □	Day Year  te to the cause of death?  Probably 4 Unknov e autopsy findings availal to the cause of the cause o
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Last) April 8,2005 3:00pm **Physician** Ruth Lois Goldberg /Medical 4b. City, Town, or Location of Death 4c. County of Death 4e Fecility Name (If not institution, give street end number) Examiner Rockville Montgomery Collinswood Nursing Center If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) March 3,1928 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Deys Hours 1□ M 2⊠F 135-20-7854 77 Yrs. Elmer, NJ Director Usuel Residence of Decedent permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylend Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28s-f show says injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location MD Montgomery Rockville 1 ¥Yes 2 □ No Be Completed by Funeral Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street end Number 20850 299 Hurley Avenue **USA** 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 SNo If Yes, Give 1 ☐ Never Merried 2 ☐ Merried White Baltimore, Maryland 21215-0020 1 ☐ Yes 2 XNo Specify: Specify: 3 Widowed 4 □ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Last) Howard Creamer 1) NKWOWN 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Reletionship (Type, Print) Gary Goldberg / Son 10 Sycamore Lane Pilesgrove, NJ 08098 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Norma, NJ Alliance Cemetery April 12.05 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Charles L. Stevens Funeral Home Inc. 1501 East Fort Ave Baltimore MD 21230 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in deeth) /Medical Dilated Cardiomyo pathy years Examiner Due to (or as a consequence of): Be Completed by Physician/Medical Examiner or Attending Physician: The law requires that the death certificeta be executed cartificate has been signed by the attending physicien end irector, page 2 should be detached for use es the bunel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Pulmonary Hypertension coronary Artery 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Disease Hypertension, Hyperlipidemia 2 No 1 ☐ Yes 2 ☐ No 1 🗆 Yes within 24 hours efter death.

To the Funeral Director: After this cartifics completely filled in by the funeral director, 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospitel: Medicai Certification: To 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospitai 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as steted.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Yeer) 29b. Signature end title of certifier P. Coellahan tyon mo April 8, 2005 041794 30. Name end eddress of person who completed cause of deeth (Item, 23a) (Type, Print)

1. Callahan - Luon, MP 911 Lusse 11 Avenue Gaittersburg, mp 20879 P. Callahan-Lyon, MP 31. Dete filed (Month, Day, Year) 32. Registrer's ignature State Registrar

			1 - For State Registrar	State of Maryland / Dep Ce	ertificate of Death		2005   3530
	Physic /Medi Examir	cal	1. Decedent's Name (First, Middle, Last)  EUGENE  4a. Facility Name (If not institution, give s	R. GILL	4b. City, Town, or Location of Death	2. Date of Death Month	Day Year 1:30pm M
			Mariner Health o	f Catonsville	Catonsville		Baltimore
	Funeral Director		5. Social Security Number 188-12-3086  Usual Residence of Decedent	7. Age (In yrs. last birthday, 81 Yrs.	If Under 1 Year   If Under 24 Hrs.   Months   Days   Hours   Min.	8. Date of Birth (Month, Day, Ye 7/8/1923	9. Birthplace (State or Foreign Country)  PA
	yland yland		10a. State 10b. County	10c. City, Town or L	ocation		10d. Inside City Limits
	e Mar Ba-f sl	ctor	MD N/A		Baltimore City		1 <b>∑</b> Yes 2 ☐ No
	th with th	Funeral Director	10e. Street and Number 1820 Spence Stree	t, Apt 7	10f. Zip Code 21230	10g.	Citizen of What Country? USA
21215-0036	a within 72 hours after death with the Maryland liene. r than "natural", or Items 23a or 28a-f show the Maydred Examinat must be notified at	by	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☑ Divorced	2. Was Decedent Ever in U.S. Armed Forces?  1	Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☑ No Specify:	ocity Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: white
5-0	72 hc	eted	15. Decedent's Educ (Specify only highest grade		edent's Usual Occupation skind of work done during most of worki	161	b. Kind of Business/Industry
121	within iene. than "	Completed	Elementary/Secondary (0-12)		DO NOT use retired)  Cab Driver	, y	Transportation
d 2	Hyg Hyg int.	Be Co	17. Father's Name (First, Middle, Last)	U		(First, Middle, Mai	
/lan	o d it b	To B	Unk.		Unk.		,
, Maryland	ges 1 and 2 should t of Health and Mer If item 27 la marke or other traumatic		19a. Informant's Name/Relationship <i>(Typ</i> Patricia Gill / Da	e, Print) 19b. Maili aughter 229	ing Address (Street and Number or Rura 1 5th Court, St. Pa	Route Number, Caul MN 5	ity or Town, State, Zip Code) 5110
Baltimore,	Pages 1 and of the source of t		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 ☐ Re	20b. Place of Dispo cemetery, cre	matory or other place)		. Location - City or Town, State
ţim	t. Pag rtment rtant: rjury o	1	'4 ☐ Donation 5 ☐ Other (Specify)	Bayview (			Baltimore City
Bal	permit. Page Department of Important: If any injury or		MW (		<sup>2</sup> Name and Address of Facility Charles L. Stevens 1501 East Fort Aver	nue, Balt	imore MD 21230
ý	Enysician /Medical		23a. Part1. Enter the disease, or complic shock, or heart failure. List only one immediate Cause (Final disease or condition resulting in death)	ations that caused the death. Do not en a cause on each line.  Due to (or as a consequence of):	ter the mode of dying, such as cardiac o		Approximate Interval Between Onset and Death
8760, <	centificate be executed with the purishment of the purish transit is as the burial-transit	lical Examiner	Sequentially list conditions, if any, leading to immediate bases. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last  b. b. c.	Due to (or as a consequence of):  Due to (or as a consequence of):			
O. Box 6	death cert	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
ds, P	es gu	by	Part II. Other significant conditions cont	ributing to death but not resulting in the u	inderlying cause given in Part I.	23e. Did tobacc	2 No 3 Probably 4 Whiknown
CO	aw requir s been si 2 should	plete	(	OFD		24a. Was an	24b. Were autopsy findings available
Vital Record		Completed		SIP CVA		autopsy performed 1 ☐ Yes 2 🗹	prior to completion of cause of death?
<u>=</u>	Phyaician: r this certificaral director,	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	spital: 1 Inpatient 2 ER/Outpatier	26. Place of Death		6 ☐Other (Specify)
ion of	nding Phi th. :: After thi e funeral o	atlon: T	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury		8d. Describe how in	
Division	Hospital or Attending 194 hours after death. Funeral Director: After tely filled in by the funer	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, str building, etc. (Specify)	reet, factory, office 2	8f. Location (Street City or Town, St	and Number or Rural Route Number, ate)
	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical	29a. Certifier (Check only one) 1 Cartifying Physical Cartifying P	cian: To the best of my knowledge, death or: On the basis of examination and/or in and manner stated.	h occurred at the time, date and place, a vestigation, in my opinion, death occurre	nd due to the cause d at the time, date a	e(s) and manner as stated. and place, and due to the cause(s)
	To the P within 24 To the Complete	W	29b. Signature and title of certifier	for Afferd	7 29c. License number D 36942		Date signed (Month, Day, Year)
	7		( ) management ( )	pleted cause of death (Item 23a) (Type, MD 1009, Freder)	Print)		21228
	Sta Registr		31. Date filed (Month, Day, Year) APR 2 1 2	32. Redistrar's Signature	park		

			1 - For State Registrar		Sta	te of M	larylar	nd / Depa		nt of H te of L			_	giene Reg. No.	200	5	13531
	Diam'r.		1. Decedent's Name	(First, Middle	. Last)		_						2. Date of De	ath Day	Yea	ar .	3. Time of Death
	Physici /Medi		Santos	5	ilva		600	nez	,				April	16	20	05	8:34 PM
	Examir		4a. Facility Name (If							, Town, or				4c.	County of D	eath	
			Universit	ry of	Maryl	and	Med	ical Ce	nter			more			NJA		
	Funeral Director		5. Social Security Nu 466-42-38	84	6. Sex 1 M 2		ge ( <i>In yr</i> s. 76	last birthday) Yrs.	Month:	er 1 Year Days	If Under Hours	Min.	8. Date of Bir (Month, Da [arch 2	th ly, Year) 19,19	29	Birthpla <i>Counti</i> Texa	ce (State or Foreign y) 1S
	and **		Usual Residence of I	10b. County			10c. Ci	ty, Town or Lo	ocation							10	d. Inside City Limits
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	the the 28a-	rect	Maryland  10e. Street and Num		Arunae.	<u> </u>		Ga	mbri 106.2	ILLS ip Code		·		10a, Citiz	zen of What	Countr	v?
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	Jeath Trs 2:	era	11. Marital Status	y rar	12. Wa	s Deceden		I.S.   13.	Was Dec			rigin? (Spec	ify Yes or No ican, etc.)		14. Race - A		
(0	ritar	Fur	1 Never Marrie	d 2[X]Marr		ned Forces ]Yes 2 <b>X</b> ′es, G <u>i</u> ve		ĺ					ican, etc.)		Black, W	hite, et	c.
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Ë	nit. Pag artment ortant: injury e		1 Burial 2x				W.	Arunde					/2005				ryland
Baltimore,	permit. Page Department of Importent: If any injury or ance.		21. Signature of Fun		Homa	<b>A</b> 1	M0095	7 D	Name Onal 411	and Addres dson Annap	s of Facili Fune: olis	<sup>ity</sup> ra1 Но коаd	ome & (	Crema	atory, Maryl	P. and	A. 21113
15			23a. Part Enter the shock, or heart	disease, or failure. List	complications only one caus	s that cause se on each	d the dea	th. Do not ent	ter the m	ode of dying	, such as	cardiac or	respiratory a	rrest,		1 1	Approximate nterval Between
No.	Physician		Immediate Cause (F	inal	- Ch	vooi	Obs	struction	re [	ulma	oncin	4 Di	Sease	>		1 '	Onset and Death
7	/Medical		resulting in death)		a	Due to (or a	s a consec	uence of):	, – 1	0.111		<del>-</del>					
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	To th Withir To th comp	Me	29b. Signature and t	tle of certifie	•				2	9c. License	number			29d. Date	signed (Mo	onth, Di	ay, Year)
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	B		30. Name and addre	- 10.0.		d cause of	death (Ite	m 23a) (Type,	Print)								
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	Sta	ate	31. Date filed (Month			22. Regis	trar's Sign										
	Regist	rar	APR	212	105	Ela.	1/2	do	Al a								

amenditem#2, per DVR, G042, 4721/05 IT State of Maryland / Department of Health and Mental Hygiene 1 - For Stete Registrar Amend Item 23a, Pt1, II per entire 68/2, 9/4/21/05dhb Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 12:15 Am 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltemore Homewood Ma Care 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 🕮 Months Days Hours 218-40-1943 Yrs. Director 20/1940 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
Inst. If item 27 is marked other than "netural", or Items 23a or 28a-f show try or other translate and item and the notified at my or other translate notified at 10h County 10c. City, Town or Location 10a State 10d. Inside City Limits 1 Yes 2 No Directo MARYLAND 10e. Street and Number 10g. Citizen of What Country? 220 ROAD USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify: 3 ☐ Widowed 4 ☐ Divorced BLACK 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 9 THGRADE College (1-4or 5+) ASSISTANT NURSING HOMES 17. Father's Name (First, Middle, Last) (ロルドルの心り) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5620 MIDWOOD AVE. 1STFL. BALTO. MD, 21215 DAUGHTER MICHELLE WEST 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date Department of H Important: If its any injury or of once. 1. Surial 2 □ Cremation 3 □ Removal from State KING MEM, PARK 04-19-05 WOODLAWN Donation 5 ☐ Other (Specify) 22. Name and Address of Facility. BROWN JR, FUNERAL HOME 2140 N. FULTON AVE. BALTO, MD 21217 21. Si mature of Funeral Service Licensee FULTON AVE., BALTO, MD 21217 23a. Part1. Efter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final Physician METASTATIC disease or condition resulting in death) Breist CANCED UNKNOW /Medical Due to (or as a consequence of): BRAIN and Lungs METASTASIS Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner sician and burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): nding physician use as the buria P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 9 Unknown 9 Unknown cate has been signed by page 2 should be detach Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown Hypertensier 24a. Was an autopsy performed? 1 ☐ Yes 2X No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Corprovence Coronary Artery Disease
25. Was case referred to medical examiner? To the Hospital or Attanding Physician: Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Diractor: / 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 124 hours af 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MD D0059056 05. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Saloja WEST MT ROYAL AVE Baltimere MD 1600 MD )alject 31. Date filed (Month, Day, Year) 82. Registrar's Signature State Registrar APR 2 1 2005

			State of Maryland / Department of Health and Mental Hygiene 2 0 0 5 1 3 5 3 3
			Registrar Certificate Of Death Reg. No.
	Physici	an .	1. Decedent's Name (First, Middle, Last)  MARY ELIZABETH GARONER  2. Date of Death Month Day Year 0.4 20PM
	/Medic Examin		4a. Facility Name (If not Institution, give street and number) 560/400, 4b. City, Town, or Location of Death  4c. County of Death
1	LAGIIII		4a. Facility Name (If not Institution, give street and number) 5601600 h. City, Town, or Location of Death  6000 C Samar, tan Hospital Backtimere  N/A
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign
	Director		214-44-8263 1 M 20 F 57 Yrs. Months Days Hours Min. (Month, Day, Year) 47 MARYLAND
	yland Iow		10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits
	e-fsh	ctor	MARYLAND BALTIMORE NOTTING HAM 10YOS 20 NO
	or 28	Olre	10e. Syfeet and Number 10f. Zip Code 10g. Citizen of What Country?
	72 hours after death with the Maryland natural', or Items 23e or 28e-1 show dical Evanting frouth by codified at	<b>Funeral Director</b>	7944 BELRIDGE RD. APTH 21236 USA.
	ter de Item	-une	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Married 2 Married 1 Status  12. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.)  14. Race - American Indian, Black, White, etc.
5-0036	urs af	by	3 □ Widowed 4 □ Divorced Specify: 1 □ Yes 2 No Specify: Specify: Specify: Specify:
5-0	hin 72 ho a. an "natur Medical	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) 16b. Kind of Business/Industry
21	H. W.	mple	Elementary/Secondary (0-12) College (1-4or 5+)
d 21	be filed wit tal Hygien d other th event, the		17. Father's Name (First, Middle, Last)  NANNY  SELF-Em PLOYED  18. Mother's Name (First, Middle, Maiden Sumame)
an		To Be	TAMES CORNISH LAURA CLAYTON
Maryland	d 2 should th and Mer 7 is marke treumatic	-	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number. City or Town, State, Zio Code)
_	thealth tem 27 in		THELMA A. WAS HING TON (SISTER) 1002 SPRING GATE RD. WITT C CATONSVILLE MD. 21225  20a. Method of Disposition  20b. Place of Disposition (Name of competent
Baltimore,	0 = 5		MD Burial 2 Cremation 3 Removal from State
Itim	nit. Pag artment ortent: I injury o		*4 Donation 5 Other (Specify)  MT. ZION CEMETERY 4-22-05 LANSDOWNE MARYLAND  21. Signature of Funeral Service Licensee  22. Name and Address of Facility & Country & C
Ba	permit. Departm Importe any inju		14 Donation 5 Other (Specify)  MT. ZION CEMETERY 4-22-05 LANSDOWNE, MARYLAND  21. Signature of Funeral Service Licensee  22. Name and Address of Facility Brown JR, FUNERAL HOME  23. 45 N. FULTON AVE. BALTO, MD, 21217
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition  a. Septic Shock
	/Medical Examiner		Due to (or as a consequence of):
	- Addining	-	Sequentially list conditions, if any, leading to immediate b. Pseudomembraneus colstiss  Due to (or as a consequence of):
(	uted 1 ansit	Examiner	cause. Enter Underlying Cause (Disease or injury  RODA + MILE TATO MALE C
ó	exection and and rial-tra		resulting in death) Last  Due to (or as a consequence of):
68760,	icate be executed physician and the burial-transit	dical	. Acute pulmonary Embol.sm
	5 5	ω .	IF FEMALE:
Вох	eath certific attending p	clan	23b. Was decedent pregnant in the past 12 months?  1
P.O.	The law requires that the death certif ate has been signed by the attending page 2 should be detached for use a	Physiclan/M	1 ☐ Yes 2 1 No 9 ☐ Unknown 9 ☐ Unknown
	es that igned to be det	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?
ord	w require been sig should b		End Stage Renal Disease 1 Yes 21 No 3 Probably 4 Unknown Diabett's Mellitus Sepsis 24a. Was an autopsy findings available prior to completion of cause of
of Vital Records,	e law r has be je 2 sh	Completed	
al F	n: The icate har r, page		Hypertens.on performed? death?  1/2/Yes 2 No 1/2/Yes 2 No
Z.	ysicien: is certific director,	o Be	25. Was care leferred to medical examiner?  1  Yes 2 1 No
1 of	g Phy ter this neral c	H-1	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred
sior	ttending I death. ctor: After y the funer	atlo	2 Accident investigation M 1 Yes 2 No
Division	or Attending Physicien: ufer death. Director: After this certifica in by the funeral director, i	Certification	3 Suicide 6 Could not be determined 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)
	pitel		29a. Certifier 11 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
	To the Hospitel or At within 24 hours after or To the Funerel Direct completely filled in by	Medical	(Check only one)    Check only one   Check o
	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fi	Me	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)
	ì		PIZZE , ME P17933 April 18, 2005
	1		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Elena 6, tels on 5601 Loch Ruven Blud, Bultimore MD21239
	Sta	te	31. Date filed (Month, Day, Year)  32. Registrat Signature
	Registr		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Elena 6, Felson 5601 Loch River Blud, Bullinove MD21239  31. Date filed (Month, Day, Year)  APR 21 2005 Seems & April

Gardner, Mary

			State of M		delible Ink. Ensure artment of Health and	-	_		
			1 - State Contificate of Death				Reg. No.		
	Physici /Medi		Decedent's Name (First, Middle, Last)     Dionisio Legaspi Garcia, J	2. Date of Month					
	Examir		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Dea	th	4c. County of Death		
	Funeral			ge (In yrs. last birthday)	Timonium If Under 1 Year If Under 24 Hr		Baltimore	place (State or Foreign intry)	
	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 Is marked other than "naturer", or items 23a or 28a-1 show the treumatic event, the Madical Examinational be invitified at		213-50-4119 Yrs. Months Days Hours Min. (Month, Day, Year) Usual Residence of Decedent					lippines	
		5	10a. State 10b. County	10c. City, Town or Lo			1	10d. Inside City Limits 1 ☐ Yes 2 ☐ No	
		rect	MD Baltimore  10e. Street and Number	Hunt \	/alley 10f. Zip Code		10g. Citizen of What Cou		
21215-0036		al Di	9 Clipping Tree Lane		21030		USA		
		by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Wildowed 4 Divorced  12. Was Decedent Armed Forces:  1 Yes, Give Year or Dates:	Ever in U.S. 13.	Was Decedent of Hispanic Origin? ( If Yes, specify Cuban, Mexican, Pue  1 ☐ Yes 2 No Specify:	Specify Yes or Norto Rican, etc.)	14. Race - Amer Black, White Specify: <b>Phi</b>	, etc.	
	hin 72 ho s. nn "natur Medicul I	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or	(Give	dent's Usual Occupation kind of work done during most of w DO NOT use retired)	orking	16b. Kind of Business/II	ndustry	
21	ed with ygiene yer tha	To Be Com	12 5÷		sician		Health Care	<u> </u>	
and	d be fill intal H ed oth		17. Father's Name (First, Middle, Last)  Colonel Dionisio Garcia, St	r		<sub>ame (First, Middle,</sub> de Legas	Maiden Sumame)		
Maryland	shouk nd Me mark umaric		19a. Informant's Name/Relationship (Type, Print)		ng Address (Street and Number or F		<u> </u>	p Code)	
Σ,	and 2 ealth a n 27 is		Jennifer G. Stefano, daugh		Tally Ho Rd., I				
Baltimore,	permit. Pages 1 am Department of Heali Impt. nt: If ftem 2 env injury or other		20a. Method of Disposition  (1 12 Surial 2 □ Cremation 3 □ Removal from State		matory or other place) 4/2	22/05	20c. Location - City or T		
ıltir	artmer artmer rinjury		2 Signature of under Service Licensee	22	Valley Memorial 2. Name and Address of Facility				
Lemmon Funeral Hom 10 W. Padonia Rd.,						lome of	Dulaney Val	ley, Inc.	
23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Physician  Immediate Cause (Final disease or condition resulting in death)  a. LIVER CANCER							rest,	Approximate Interval Between Onset and Death	
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	be executed cian and burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events  c.	a consequence of):					
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O. Box	The law requires that the death certificate be executed tte has been signed by the attending physician and tage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1					23d. Date of delivery Month Day Year	
rds, P.	w requires that been signed by should be deta	by						co use contribute to the cause of death?  2 No 3 Probably 4 XUnknown	
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	Physician: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ▼No Hospital: 1 ☐ Inpati		0.1	eath (Check only o		HOODTON	
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sior	Attending I r death. sctor; After by the funer	atlo	2 Accident investigation	y reary injury	M 1 ☐ Yes 2 ☐ No				
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	To the Hospitel within 24 hours a To the Funerel C completely filled	edical							
)	Withi Comp	M	29b. Signature and title of pertifier		29c. License number D43724		29d. Date signed (Month,	Day, Year)	
	4		30. Name and address of person who completed cause of						
	Sta		DR. TARIO MAHMOOD 2300 D 31. Date filed (Month, Day, Year) 32. Regist APR 2 1 2005	TILANEY VAL.	LEY RD. TIMONIUM	1, MD 210	93		
DH	Regist	, 12	APK 2 1 2003						

	i içası	State of Manuand / I	Department of Health	-			
	For State Registrar	State of Maryland / 1	Certificate of Death	h	g. No. 2005 13535		
Physician	1. Decedent's Name (First, Middle, L	ON HARRIS		2. Date of Death Month			
/Medica Examiner	A 400 100 A 51 100 A 5 100 A 5	ve street and number)  ND DR. APT#	4b. City, Town, or Location	n of Death  ACTIMORE	4c. County of Death		
Funeral Director	397-30-6464	Sex 7. Age (In yrs. last bit	rthday) If Under 1 Year If Under 1 Year Months Days Hours	er 24 Hrs. 8. Date of Birth	9. Birthplace (State or Foreign		
death with the Maryland me 23s or 28e-f show rrust be notified at paral Director	Usual Residence of Decedent  10a. State  10b. County	10c. City, Tow	DATTIMORE		10d. Inside Oity Limits 1 Nes 2 No		
ar death with the Marylar teme 23a or 28e-f show normust be notified at inneral Director		LAND TRAPT	10f. Zip Code 2	1234	g. Citizen of What Country?		
0036 hours after death vural; or iteme 23		12. Was Decedent Ever in U.S. Armed Forces? 1 Let'es 2 □ No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic C If Yes, specify Cuban, Mexic		14. Race - American Indian, Black, White, etc.  Specify: DLACK		
21215-00 ed within 72 hou ygiene. ner than "natura it, the Madical E.	15. Decedent's 8 (Specify only highest g  Elementary/Secondary (0-12)	Education 16a	Decedent's Usual Occupation (Give kind of work done during mo- life. DO NOT use retired)	ost of working	5b. Kind of Business/Industry		
			EANTY SUPPLY L	her's Name (First, Middle, M.	DISTRIBUTION		
ryland ryland nould be fi d Mental H narked ott netic ever	NEAL H	ARRIS, SR.		ANNIE	GPRDON		
9, Mary and 2 shou lealth and N m 27 le ma her treume	19a. Informant's Name/Relationship	V DAUGHTER 6	o. Mailing Address (Street and Num  SUI — G & VEENS  1 Disposition (Name of	S FERRY ROAL	BACTO, MD 21239		
Itimore iit. Pages 1 irtment of P ortent: If ite njury or ot	20a. Method of Disposition  1 Warial 2 Cremation 3  4 Donation 5 Other (Spec	☐Removal from State cemete	ry, crematory or other place)  SON FOREST	1	Dc. Location - City or Town, State  UNGS MILLS, MARILAND		
Baltir permit. P Departme Importen any injur	21. Signature of Funeral Service Lice		22. Name and Address of Fac		GREENE FUNEXITY HM.		
Physician	Immediate Cause (Final	mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, line and Death Unknown					
/Medical Examiner	disease or condition resulting in death)	a.  Due to (or as a consequence	1/13/2006				
executed executed ial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequence of):  AUTONAMIC AND PERIPHERAL NEUROPATHY 5 YEARS					
760 te be ysicia		Due to (or as a consequence of):  d. INSULIN DEPENDANT DIABETES /0480V.					
BOX 6 ath certif titlending or use as	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delivery Month Day Year		
Hecords, P.O.  The law requires that the de e has been signed by the a age 2 should be detached modeled by Physic	LIVDER	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco					
aw requir	HYPER	LIPIDEMIA	2	24a. Was an	24b. Were autopsy findings available		
	LACUNA	R INFARCT	3	autopsy performe 1 ☐ Yes 2	prior to completion of cause of death?  XNo 1 ☐ Yes 2 ☐ No		
VITAL IN Incien: The certificate rector, page	25. Was case referred to medical examiner?	26. Place of Death (Check Hospital: 4 Dispersion) 25 FROM the Company of the Comp					
on of ding Physical After this of funeral direction: To		28a. Date of Injury 28b. Time of Injury Work? 28c. Injury at Work?		28d. Describe how	ome 5 Residence 6 □Other (Specify)  28d. Describe how injury occurred		
the tree to	2 Accident investigation 3 Suicide 6 Could not determined	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory office 28f, Location /Str.			eet and Number or Rural Route Number, State)		
DIVI the Hospitel or At in 24 hours after of the Funerel Direct pletely filled in by		hysician: To the best of my knowledge miner: On the basis of examination an and manner stated.	e, death occurred at the time, date and/or investigation, in my opinion, de	and place, and due to the causeath occurred at the time, dat	se(s) and manner as stated. e and place, and due to the cause(s)		
To the within 2 To the Complete	29b. Signature and title of certifier	la Pain MD	D412		d. Date signed (Month, Day, Year) 4/19(05		
3	30. Name and address of person who	completed cause of death (Item 23a)	(Type, Print) HEALAMEDA,	BALTIMO	PE, Md 21218		
State Registrar	31. Date filed (Month, Day, Year)	32. Registrar's Signature	South !				

			1- For State of Mar		artment of He		ental Hygier	DODE	13536
	Physicia /Medica	al	1. Decedent's Name (First, Middle, Last)  Retty Jane, Ho  4a. Facility Name (If not institution, give street and number)	gne	4b. City, Town, or L	F	April Zo	Day Yea	1105AM
	Examin	er	Harbor Hospital	(In yrs. last birthday)	Baltim	note		Baltim	
	Funeral Director		10 M 2 M E	76 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Yes 08/05/1	928	PA
0036	n the Maryland r 28e-f show	ctor	10a. State 10b. County 1	10c. City, Town or Li Balti:					10d. Inside City Limits 1   Yes 2  No
	with th	Director	10e. Street and Number		10f. Zip Code 21225			Citizen of What	Country?
	within 72 hours after death with the Maryland ene. Then "natural", or Itams 23a or 28e-f show the Madical Examiner must be natitied at	To Be Completed by Funeral	4501 Virginia Avenue   11. Marital Status   12. Was Decedent Ev. Armed Forces?   1		Was Decedent of Hisl If Yes, specify Cuban, 1 ☐ Yes 2 No	Specify:	ity Yes or No- ican, etc.)	14. Race - Ar Black, W Specify:	White
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Maryland	should be ind Mental marked o		Leonard Leroy Rapp				izabeth		
	2 a a a		19a. Informant's Name/Relationship (Type, Print)  Matt Hoque / Son		ing Address (Street an Riversi				
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<u>=</u>	Pa men ent: ury		' 4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licenses		Cty Mem I			adford	
e E	permit. Departi Import any inj		I Sul Sur		169 Rivie	era Driv	e, Pasa	runera dena,	1 Home, PA MD 21122
	Physician /Medical		23a. Part1. Enter the discusse, or complications that caused the shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)	515	iter the mode of dying,	such as cardiac or	respiratory arrest,		Approximate Interval Between Onset and Death
E	Examiner  be executed  ysician and  be burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a condition of the cause)  Due to (or as a condition of the cause)  Due to (or as a condition of the cause)  Due to (or as a condition of the cause)  Due to (or as a condition of the cause)	consequence of):  Cance  consequence of):	d J				6 months
O. Box 6	he death certifica r the attending ph ched for use as th	hysician/Me	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 ☑ No 9 □ Unknown  23c. If yes, outcome of 1 □ Live birth 2 (4 □ Pregnant at times 10 □ Vinknown)	Fetal death 3	⊒Ectopic pregnancy ⊒ Other (specify)			23d. Date of d Month	lelivery Day Year
7.	law requires that the de as been signed by the a 2 should be detached t	o Be Completed by Ph	Part II. Other significant conditions contributing to death but	not resulting in the u	underlying cause given	in Part I.			to the cause of death?  Probably 4 _Unknown
I Kecords,	he h						24a. Was an autopsy performed	prior to	autopsy findings available o completion of cause of ?
on of Vital	ysician: tis certifica director,		25. Was case referred to medical examiner?  1  Yes	• 🗆	Othor	26. Place of Death /			
	ding Pt n. After th funeral	$\vdash$	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation  Hospital: 1 Impatient 28a. Date of Injury (Month, Day Y	nt 3□ DOA					
DIVISION	of or Attence after death Director:	ertification;	2 □ Suicido 6 □ Could not be	/ - At home, farm, sti (Specify)	reet, factory, office	28	3f. Location (Street City or Town, Sta	and Number or a	Rural Route Number,
	To the Hospitel or Atte within 24 hours after de To the Funeret Directo completely filled in by th	edical C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of real meaning states and manner states	xamination and/or in	th occurred at the time exestigation, in my opin	, date and place, an nion, death occurred	id due to the cause f at the time, date a	(s) and manner nd place, and d	as stated. ue to the cause(s)
	To th withir To th	Me	29b. Signature and title of certifier  M. M	D	29c. License r	- 00	1 An	Date signed (Mo	2005
	8		30. Name and address of person who completed cause of dear Peter Kratz 3001 Sout	th (Item 23a) (Type,		- Baltir	nore, Mi	0212	25
	Sta ~ Registr		31. Date filed (Month, Day, Year)  APR 2 1 2005	s Signature					

			1- State of Maryland / Department of Maryland	artment of Health and Me rtificate of Death	ental Hygier	711115	13537
	Physici /Medic	cal	Decedent's Name (First, Middle, Last)     RUTH ANDREWS HOLLAND  4a. Fecility Name (If not institution, give street and number)			2005 Year	3. Time of Death 3:45A M
	Examin	ier	Keswick Home  5. Social Security Number  220-32-9743  6. Sex  7. Age (In yrs. last birthday)  Yrs.	Baltimore	8. Date of Birth (Month, Day, Yes March /, 1	N/A	ace (State or Foreign frx) Carolina
	Director Modes	or	Usual Residence of Decedent  10a. State  10b. County  10c. City, Town or Let	ocation	march 7,1		Od. Inside City Limits
th with the N	23a or 28a-f	Funeral Director	Maryland N/A Baltimor  10e. Street and Number  700 West 40th Street	10f, Zip Code 21211	10g. (	Citizen of What Count	
<b>-UU36</b> hours after death with the Maryland	ral', or items 23a or 28a-f show Exeminer must be mulfied at	by Funer	1 □ Never Married 2 □ Married 1 □ Yes 2 1 □ No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Spec If Yes, specify Cuban, Mexican, Puerto R 1 ☐ Yes 2 (No Specify:		14. Race - America Black, White, e	
d 21215-0036	giene. er than "natural", , the Medical Exe	Completed by	Flementary/Secondary (0-12)   College (1-40r.5+)	dent's Usual Occupation kind of work done during most of working DO NOT use retired) rial Assistant	g 16b.	Newspape	
aryland should be file	la do	To Be (	17. Father's Name (First, Middle, Last) Edgar Clessie Andrews  19a. Informant's Name/Relationship (Type, Print)  19b. Mailit	18. Mother's Name (Mary Wi	ilson		Control
re, Ma standzsi	m 27 is m 27 is her tra		J Ward Holland Jr Son 922 J  20a. Method of Disposition 20b. Place of Dispo	uliet Road Arnold N	Maryland		
Baitimore, Maryland permit. Pages 1 and 2 should be file	ment cant: If		Donation 5 Other (Specify) Parkwood	Cemetery 4/22/0	hell-Wiedef	ltimore, M Id Funeral H more, Maryla	ome Inc
xecuted Electrical States	nysician Medical xaminer	Examiner	23a. Part 1. Enter the disease or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):		respiratory arrest,		Approximate Interval Between Onset and Death
.O. BOX 68/60	ittending p	Physician/Medical		□Ectopic pregnancy □ Other (specify)		23d. Date of deliver	ry Day Year
SCORGS, P	been signed b	Completed by PI	Part II. Other significant conditions contributing to death but not resulting in the under the conditions contributing to death but not resulting in the under the conditions contributing to death but not resulting in the under the conditions contributing to death but not resulting in the under the conditions contributing to death but not resulting in the under the conditions contributing to death but not resulting in the under the conditions contributing to death but not resulting in the under the conditions contributing to death but not resulting in the under the conditions contributing to death but not resulting in the under the conditions contributing to death but not resulting in the under the conditions contributing to death but not resulting in the under the conditions contributing to death but not resulting in the under the conditions contributing to death but not resulting in the under the conditions contributing to death but not result in the conditions contributing to death but not result in the conditions contributing to death but not result in the conditions conditions contributing to death but not result in the conditions conditions contributing to death but not result in the conditions contributing to death but not result in the conditions conditions contributed by the conditions conditions conditions contributed by the conditions conditio	nderlying cause given in Part I.	1 ☐ Yes	24b. Were autop	e cause of death?  bly 4  Unknown  sy findings available interior of cause of
Of VITAL MO	ector, p	To Be Cor	25. Was case referred to medical examiner?  1  Yes  No  Hospital: 1 Inpatient 2 ER/Outpatier	26. Place of Death (		death? 1 Yes  6 Other (Specify,	2 No
DIVISION OF 1 or Attending Phy	i fe	Certification:	27. Manner of Death  1 Natural 5 Pending investigation  3 Suicide 6 Could not be determined  4 Homicide 28a. Date of Injury (Month, Day Year)  28b. Time of Injury (Month, Day Year)  28b. Place of Injury - At home, farm, str building, etc. (Specify)	Work? M 1 ☐ Yes 2 ☐ No	8d. Describe how in 8f. Location (Street City or Town, Sta	and Number or Rural	Route Number,
U To the Hospital o		Medical Cel	29a. Certifier (Check only one)  Certifying Physicien: To the best of my knowledge, deatled, on the basis of examination and/or in and manner stated.	n occurred at the time, date and place, ar vestigation, in my opinion, death occurred	nd due to the cause d at the time, date a	(s) and manner as sta and place, and due to	ited. the cause(s)
Toth	within To th compl	Me	29b. Signature and title of certifier	29c. License number		pate signed (Month, C	ZOO)
	6		30. Name and address of person who completed earlies of death (Item 23a) (Type,	Print) Street Balt	Enere	21211	
	Sta Registr	_	31. Date filed (Month, May, Year)  APR 2 1 2005  32. Ruistrar's Signatures	fierk)			

			1- For Amend Item 4a )	tate of Manyla	nd /22eg Ce	rtment of F	lealth ar <i>Death</i>	nd Menta	l Hygien	2005	135	38
	Physici	an	Decedent's Name (First, Middle, Last)					2. Date APR	e of Death	200 <sup>year</sup>	3. Time of D	)eath
	/Medic	cal	KENNETH JAY	-1 (		HANN 4b. City, Town, o					7:24a	М
	Examir	ier	4a. Facility Name (If not institution, give street 7301 LEMONS BRUICE Bridge	OAD	last hirthday	BOWIE  If Under 1 Year	If Under 24		PF	c. County of Deat RINCE GEO	ORGES	
	Funeral Director		5. Social Security Number 6. Sex 1 1 1 N N  Usual Residence of Decedent	000	. last birthday)	Months Days		Min. (Mo.	e of Birth nth, Day, Year 03/1966	)   Co	thplace (State or in buntry)	roreign
	nyland how		10a. State 10b. County		ity, Town or Lo	cation					10d. Inside City	Limits
	88-fs	Director	MD PRINCE GEOF	GES BOW	IIE						1 X Yes 2	2 🗆 No
	with th		10e. Street and Number			10f. Zip Code			10g. C	itizen of What Co	ountry?	
	ns 23	Funeral	14649 LONDON LANE  11. Marital Status 12	Was Decedent Ever in t	J.S. 13.	20715 Was Decedent of H	lispanic Origin	n? (Specify Ye	s or No-	U.S.A.	rican Indian.	
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural; or Items 23a or 28a-f show other traumatte event, it is Mudical Evan, at minal transfelled at	<b>Δ</b>	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2☐ No	an, Mexican, I Specify:	Puerto Rican, e	etc.)	Black, Whit Specify:		
5-0	"natu	etec	15. Decedent's Educat (Specify only highest grade of		(Give	dent's Usual Occup kind of work done	during most o	of working	16b.	Kind of Business/	Industry	
12	withir iene. than	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retire AGER	a)			IKEA		
DG 2	e filed other vent,	Be C	17. Father's Name (First, Middle, Last)		1 17 (147	ICLIV	18. Mother's	s Name (First,	Middle, Maide			
Maryland	2 should be filed within and Mental Hygiene. Is marked other than aumatic event, The Ms	ToE	IRWIN			HANN	MURI	EL			SACH	S
Mar	d 2 sh th and 7 is rr traurr		19a. Informant's Name/Relationship (Type FAZIELA HANN / WIFE	•		ng Address (Street					Zip Code)	97
	thealth tem 27 i		20a. Method of Disposition	20b.	Place of Dispo	9 LONDON sition (Name of		BOWIE,	20c. l		Town, State	
E	Page ent o nt: # ny or		1 🗖 Burial 2 □ Cremation 3 🏹 Ren  1 4 □ Donation 5 □ Other (Specify)	oval from State BET	Cemetery, crei	natory or other plac	4/2	20/2005	WAS	Ocation - City or HINGTON	TOWNSHI	
Baltimore,	permit. Pages 1 and Department of Health Important: if Item 27 any injury or other tr		21. Signature of Funeral Service Licensee	,	22	2. Name and Addre					, INC.	
			23a. Part1. Enter the disease, or complica shock, or heart failure. List only one	ions that caused the dea						OVILLE	Approximate Interval Between	een
	Physician (Madisal		Immediate Cause (Final disease or condition resulting in death)	Intraoral	Shoto	un wou	und				Onset and De	ath
	/Medical Examiner		resulting in dealthy	Due to (or as a conse	quence of):							
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse	quence of):						- HOUSE - TE-	
	ecuted Ind transil	Examine	Cause (Disease or injury that initiated events resulting in death) Last									
8760,	ate be executed hysician and the burial-transit		resulting in death) Last	Due to (or as a conse	quence of):							
687	ficate g phys	edicai	d									
Вох	leath certific attending p	M/M	230. Was decedent pregnant	If yes, outcome of pregr 1☐Live birth 2☐Fet		Ectopic pregnancy	,			23d. Date of deli	ivery	
O. B	The law requires that the death certificate be executed tte has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Me	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4☐ Pregnant at time of 9☐ Unknown		Other (specify)				Month	Day Ye	ar
Р.	res that the igned by be detac	y Ph	Part II. Other significant conditions contri	outing to death but not re	sulting in the u	nderlying cause giv	en in Part I.	236	e. Did tobacco	use contribute to	the cause of dea	ath?
Vital Records,	equires en sign	ed by						_ (1	1 ☐ Yes 2	2 □ No 3 □ Pro	obably 4 🗆 Uni	known
eco	e law requ has been je 2 shoul	Completed						248	i. Was an autopsy	24b. Were au	topsy findings av	ailable
		Con						102	performed? Yes 2□N	death?		
Zit.	Physician: this certificaral director,	o Be	25. Was case referred to medical examiner?  11 Yes 2 No	pital:	750/0-1-1	t 3 DOA Oth	0.00	f Death (Check		Y.	SCENE	_
			27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of	I JU DON	4 🗀 14013	ing Home 5 28d. Des	⊒ Residence scribe how inju	6 Other (Spec ary occurred	ony) COLLIE	
sior	Attendin death. ctor: Af y the fur	atio	1 □ Natural 5 □ Pending 2 □ Accident investigation 3 ☑ Suicide 6 □ Could not be	in 18 2005	Fundary 30		Yes 2 🗷 No	sub	oje ct	shot	sett	
Division	I or Attend efter death Director: ,	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At I building, etc. (Spec	ify)	eet, factory, office		City	or Town, Stat		aral Route Number	<i>}1</i> ′,
_	To the Hospital or Attending within 24 hours effer death.  To the Funeral Director: After completely filled in by the fune.		29a. Certifier 1 ☐ Certifying Physic	an: To the best of my kn	owledge, deat	occurred at the tir	me, date and i	place, and due	to the cause(s	30 and manner as	stated	)
	he Ho in 24 l he Fu pletely	edical	(Check only and Medical Examine)	On the basis of examin and manner stated.	ation and/or in	vestigation, in my o	pinion, death	occurred at the	time, date ar	d place, and due	to the cause(s)	
	Mith To t	Σ	29b. Signature and title of certifier			29c. Licens	e number		29d. D. AP	RIL 18,	2005	
,			Jashel -	reenly	Mo	OCME						
			30. Name and address of person who comp		m 23a) (Type,		Penn St	reet 1	Ral+ima	Mo Mo	7 0 1 01	207
	Sta	te	31. Date filed (Month 173 Prayr) 1 200	_ 32. Flesistrar's Sign	ature	4	ال تست	TCCL ]	ua <u>ı LIIIC</u>	re, Mary	zand ZI	ŹUI.
	Registr	ar	× T ZUL	5 Alexan	A A	SHALL SHALL						

Physic	ian	1. Decedent's Name (First, Middle, Last)  Dale Lee Justice				2. Date of Death	9, 2005 Year	3. Time of Death 3:45 P
/Medi Exami	cal	4a. Facility Name (If not institution, give street and number 11227 ALBETH RD	or)	4b. City, Town	, or Location of Dea		4c. County of Death	I
Funeral Director		5. Social Security Number 220–96–8521 6. Sex $2 \square F$ 4. Usual Residence of Decedent	Age (In yrs. last birthd 2 Yrs	Months Day			Year) 9. Birth	place (State or Fore
Maryland a-f show	ctor	10a. State 10b. County Md Howard	10c. City, Town or Woodst					10d. Inside City Lim
ath with the 23a or 28 ust be not	rai Director	10e. Street and Number 11227 Albeth Road		10f. Zip Code 21163		10	og. Citizen of What Cour USA	ntry?
2 should be filed within 72 hours after death with the Maryland and Mental Hyglene. Is marked other than "natural", or items 23a or 28a-f show reumatic event, Ite Medical Examinar must be notified at	by Funeral	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced  12. Was Decede Armed Force 1 Yes, Give Year or Date:	XNo	3. Was Decedent of If Yes, specify Control of Image 1	f Hispanic Origin? (: uban, Mexican, Pue lo Specify:	Specify Yes or No- nto Rican, etc.)	14. Race - Ameri Black, White, Specify: Whi	etc.
id within 72 h glene. er then "natu	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  12  College (1-4c)	(G	cedent's Usual Occ ive kind of work dor e. DO NOT use reti Carpente	ne during most of wo red)	orking	6b. Kind of Business/In	
ould be file   Mental Hy   Marked oth   hatic event	To Be (	17. Father's Name (First, Middle, Last) Robert Lee Justice			Peggy 3	me <i>(First, Middl</i> e, <i>M</i> Jane Bridn	er	
permit. Pages 1 and 2 should Department of Health and Men Importent: If item 27 is marke any injury or other treumatic ODCS.		19a. Informant's Name/Relationship (Type, Print)  David M. Justice (brother)  20a. Method of Disposition  1 ⚠ Burial 2 □ Cremation 3 □ Removal from Sta  4 □ Donation 5 □ Other (Specify)	20b. Place of Discemetery,		Ave., Syk	cesville,	City or Town, State, Zip Md 21784 Oc. Location - City or To arriottsvil	own, State
permit. P Departme Importen any injur.		21. Signature of Funeral Service Licensee		22. Name and Add	ress of Facility Ha		ral Home &	
wate be executed / Medical Examination and whysician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. External underlying Cause (Disease or injury that initiated events  C.	as a consequence of): as a consequence of): as a consequence of):	Cartiovas	cuiai bis	ease		
To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Completed by Physician/Medi		2 ☐ Fetal death at time of death	3 □Ectopic pregnar 5 □ Other <i>(specify)</i>	ncy		23d. Date of delive	ory Day Year
v requires that been signed b should be det	ted by P	Part II. Other significant conditions contributing to death Organizing pneumonia assoc	_				acco use contribute to th 3 ☐ Prob	
ician: The law recertificate has be rector, page 2 sho		disease  25. Was case referred to medical					ed? prior to condeath?  No 1 X Yes	psy findings avail npletion of cause 2 No
vttending Physician: death. ctor: After this certific y the funeral director,	Certification; To Be	examiner?  1 X Yes 2 No  1 Inpa  27. Manner of Death  1 X Matural 5 Pending 2 Accident investigation  28a. Date of Ir (Month, Decident)	jury 28b. Time Day Year) Injur	e of 28c. Inj y W	Other: 4 Nursing I ury at lork? Yes 2 No	28d. Describe how	ice 6 <b>X</b> Other ( <i>Specif</i> ) vinjury occurred	
To the Hospitel or Attenwithin 24 hours after deation to the Funerel Director: completely filled in by the		4 Homicide determined 256. Place of 1 building.  29a. Certifier 1 Certifying Physician: To the bes	njury - At home, farm, etc. (Specify) st of my knowledge, de	eath occurred at the	time, date and place	City or Town,	ISB(s) and manner as st	ated
To the Hospitel within 24 hours a To the Funerel I completely filled	Medical	(Check only one)  2 Medicel Exeminer: On the basis and manner  29b. Signature and title of certifier  Which was a signature and title of certifier	of examination and/or	29c. Lices	nopinion, death occi	urred at the time, dat	d. Date signed (Month, APRIL 20, 20)	the cause(s)  Day, Year)
				OCI	'IC	_		

			1 - For State Registrar	State of	Maryland	-	artmen rtificat					giene Reg. No.	2005	13540
	Physici	an	Decedent's Name (First, Middle							2	2. Date of De Month	Day	Year	3. Time of Death
	/Media		JAMES		KNISLEY,	JK.					pril	15,	2005	4:00 a <sup>M</sup>
4	Examir	ner	4a. Facility Name (If not institution	•					Location				County of Deat	
			161 Fair Prospec			h faith alous	If Under		nsvil If Under		Data (Pie		Queen A	
	Funeral Director		5. Social Security Number 219-26-8061	6. Sex 7.	. Age (In yrs. last 66	Yrs.	Months	Days	Hours	Min. M	B. Date of Bird (Month, Da larch 1	y Year)	9. Birt	thplace (State or Foreign buntry) Maryland
			Usual Residence of Decedent	AA	- 00					1.1	lai CII I	. J , I	939 1	var y rand
	yland Now		10a. State 10b. County		10c. City, T	own or Lo	ocation				-			10d. Inside City Limits
	Mar 9-1-81	to	Maryland Queer	Annes	Ste	vens	ville							1 ☐ Yes 2 ☐ No
	or 28	ire	10e. Street and Number				10f. Zip	Code		,		10g. Citiz	en of What Co	ountry?
	72 hours after death with the Maryland natural', or Items 23a or 28e-1 show dietal Exatra ne must be truffied at	Funeral Directo	161 Fair Prospec	t Farm Cou	urt			2166	6			U.S	.A.	
	r dea	Iner	11. Marital Status	Armed Forc	lent Ever in U.S.	13.	Was Deced	dent of Hi	spanic Ori	igin? (Speci	ify Yes or No ican, etc.)	- 1	4. Race - Ame Black, White	
36	or li	by Fu	1 Never Married 2 Marri	If Yes, Give		1	1 Yes		Specity:				Specify:	
8	hour tural	od b	3 Widowed 4 Divorced	Year or Date		So Door	domila I lave	1.000	41				V	Vhite
21215-0036	in 72	Completed	(Specify only highes	t grade completed)		(Give	dent's Usua kind of wo DO NOT us	rk done d	turina mos	t of working	7	160. Kin	d of Business/	Industry
212	filed within Hygiene. ther then other, the Mex	mo	Elementary/Secondary (0-12) Grade 12	College (1-4	4or 5+)		duce i					Gro	cery	
	be filed within 72 hours after death with the Marylan stal Hygiene. Id other then "natural", or Items 23a or 28e-f show other then "natural", or Items 23a or 28e-f show event, the Markinal Expira not must be rivilled at	Be C	17. Father's Name (First, Middle, I	.ast)					18. Mothe	er's Name (	First, Middle,			
Maryland	should be filed and Mental Hygi s marked other umatic event, I	To B	James W. Knisley	,					Ever	Hobb	S			
ary	d 2 should th and Men 7 Is marke traumatic	-	19a. Informant's Name/Relationsh	iip (Type, Print)	4.	19b. Mailir	ng Address	(Street a	ınd Numbe	er or Rural F	Route Numbe	er, City or	Town, State, 2	Zip Code)
	C = 01 L		Penelton Knisley	/ spouse						Farm	Ct. S	teve	nsville	e, MD 21666
altimore,	ges 1 and t of Healt if item 2 or other		20a. Method of Disposition 1 □ Burial 2 ☒ Kremation	3 □ Removal from St	20b. Place ceme	e of Dispo etery, crei	sition (Nan	ne of ther place	9)	Dat	te	20c. Loc	ation - City or	Town, State
Ë	Pag ment ant:   ury c		'4 □ Donation 5 □ Other (Sp			runde	el Cre	emato	ory	4/20/	2005	Ode	nton, M	Maryland
Ball	permit. Pages. Department of H Important: If ite any injury or of		21. Signature of Funeral Service I	icensee.		2	Name an Donald	d Addres	s of Facilit Fune	ral H	ome,P.	Α.		
=	40 F 4 9		48 > 47	~	/ M007	/0 3	313 Ta	albot	t Av	enue	Laure	1, Ma	aryland	
l,			23a. Part1. Enter the disease, or shock, or heart failure. List	apmplications that cau only one cause on eac	used the death. I ch line.	o not ent	er the mod	e of dying	g, such as	cardiac or r	respiratory ar	rrest,		Approximate Interval Between Onset and Death
	Pnysician / /Medical		Immediate Cause (Final disease or condition resulting in death)		onary Ar	_	Disea	ase						2003
	Examiner				rasa consequen ertensio:									1005
		-	Sequentially list conditions, if any, leading to immediate	b	r as a consequen									1995
d	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Cluses or injury that initiated events											
	be executed sician and burial-transit	Exa	resulting in death) Last	Due to (or	r as a consequen	ce of):								
8760,	ate be hysicia the bu	ledicai		d										
9	death certificate e attending physi d for use as the	Med	IF FEMALE:											
Вох	attendi for use	an/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outco	ome of pregnancy th 2 Fetal de		Ectopic pr	egnancy				23	3d. Date of deli Month	ivery Day Year
0	at the de by the a tached f	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Pregnar 9☐ Unknow	nt at time of death vn	1 5□	Other (sp	ecify)					,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	oay roar
σ.	that if		Part II. Other significant conditio	ns contributing to dea	th but not resultin	a in the u	nderlying c	ause cive	n in Part I.		23e. Did to	obacco us	e contribute to	the cause of death?
Vital Records,	og og	d by				•	, , ,					/es 2□		obably 4 \( \sum Unknown
50	w requir been si should	ompieted									24a. Was	an	24h Were au	topsy findings available
Re	The la	ошо				-					autop	rmed?	prior to death?	completion of cause of
tal	ilcien: T certificat rector, p	e C	25. Was case referred to medical						26 Place	of Death //	1 ☐ Yes Check only o	2 🔯 Xio	1 ☐ Yes	2[X] <b>K</b> o
$\geq$	dis y	To B	examiner? 1 ☐ Yes 2 🏋 🗓 o	Hospital: 1  Inp	patient 2□ER/	Outpatier	it 3 DO	A Othe					☐Other (Spec	cifv)
u of			27. Manner of Death  1 XXatural 5 □ Pending	28a. Date of (Month,	Injury 28I Day Year)	b. Time of Injury	2	8c. Injury Work			d. Describe h			
<u>Ö</u> .	Attending r death. ector: After by the fune	atic	2 Accident investig	ation			М		′es 2 🗆 !	No				
Division	l or Atten after deatl Director: I in by the	ertification;	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	ned 28e. Place of	f Injury - At home g, etc. (Specify)	, farm, str	eet, factory	, office		281	f. Location (S City or Tow		Number or Ru	ral Route Number,
	Hospitel (14 hours a Funerel D Funerel D tely filted i	O	COO Comiliar 1XX comitiving	Dhysiology To the b		d								
	To the Hospitel or At within 24 hours after of To the Funerel Direct completely filled in by	edicai	29a. Certifier 1♠ Certifying (Check only 2 Medical E	g Physician: To the be examiner: On the basi and manne	is of examination	and/or in	vestigation,	in my op	e, date and inion, deat	th occurred	at the time,	date and p	nd manner as place, and due	stated. to the cause(s)
	To the within 2. To the complet	Me	29b. Signature and title of certifier	0	J*)		29c	. License	number			29d. Date	signed (Month	n, Day, Year)
)	1		Konno	de K	if I	CO		D00	3637	1		Ap	oril 15	, 2005
	17		30. Name and address of person v	· ·			•							
	0		Raymond E. Banf 31. Date filed (Month, Day, Year)		2002 Med gistrar's Signature		Park	way	Ste.	670	Annap.	lois,	MD 2	1401
	Sta Registr	-	APR 2 1 20	_		Spars	E							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last, 3. Time of Death Month **Physician** 9:58 AM arev OOKe 4 2005 /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town or Location of Death Examiner Univers 5. Social Security Number 6 Sex **Funeral** 1□M 2XF Director N/A 10 2005 Maryland Usual Residence of Decedent with the Maryland 10b. County 10a. State 10c. City. Town or Location 10d. Inside City Limits or 28a-f show 7 is marked other than "natural", or items 23s or 28s-f shov traumatic svent, the Modical Externition must be notified at 1 ☐ Yes 2 ▼ No Director PAYork Hanover 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death 614 Broadway 17331 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: if item 27 is marked other than "natural", or ite 1 ☐ Yes 2 X No 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No If Yes, Give Year or Dates: Specify: Š 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) N/A N/AN/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Joseph P. Karevy Jennifer Kohlhepp 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2: Department of Health ar Important: if item 27 is any injury or other trau once. Joseph P. Karevy Father 614 Broadway Hanover, PA 17331 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 

Burial 2 □ Cremation 3 □ Removal from State April 19, \* 4 ☐ Donation 5 ☐ Other (Specify) Emmanuel Luth. Cem. Manchester, MD 2005 22. Name and Address of Facility Burrier-Queen Funeral Home & Crematory, 1212 W. Old Liberty Road Winfield, MD P.A. 21784 oul 23a. Part 1. Enter the disease, of complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Congenital Healt Discuse Immediate Cause (Final Physician lications disease or condition resulting in death) /Medical Examiner arteriosus + interrupted aortic arch + USD Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Division of Vital Records. P.O. Box 68760. attending physician for use as the buria Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 X No 24a. Was an page 2 s autopsy Yes To the Hospital or Attending Physicien: 25. Was case referred to medical examiner?

Yes 2 □ No Be 26. Place of Death (Check only one Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient Medical Certification: To 2 ER/Outpatient 3 DOA Director: After th Date of Injury (Month, Day Year) 28c. Injury at Work? Manner of Death 28b. Time of 28d. Describe how injury occurred Natural 5 Pending investigation death. 1 Yes 2 No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined after 4 \ Homicide within 24 hours a To the Funerei L ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier completely and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature any title of a rtifler 29c. License number 8

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

APR 2 1 2005

32. Registrar's Signature

NSE13, 225. Greene St, Baltimole, MD21201

		•	For State Registrar	State of Maryland /	Department of He Certificate of D		ital Hygiene Reg. No.	211115	13542
	Physici /Medic	an	1. Decedent's Name (First, Middle, Last)	Elebe			Date of Death  Month Day	4 05	3. Time of Death 7:30 Pm
	Examin Funeral Director	er	4a. Fecility Name (If not intitution, give s  Mary land Tran  5. Social Security Number  216-86-2467  6. Sex	sitionalle	4b. City Jown, or Level Balt birthday)  If Under 1 Year  Months Days	imore	Mol E Date of Birth (Month, Day, Year) OV 12, 19	Counti	ore (State or Foreign /
	D	or	Usuel Residence of Decedent  10a. State 10b. County  MD	10c. City, To	own or Location Baltimore			10	Dd. Inside City Limits 1 1 Yes 2 □ No
	with the h	i Director	10e. Street and Number 954 Forrest Avenu	ıe	10f. Zip Code	21202	10g. Cit	tizen of What Count	try?
936	be filed within 72 hours after death with the Maryland hal Hygiene. Id other then "natural", or Items 23a or 28a-f show other then "natural", or Items 23a or 28a-f show event, the Modical Examinar meat be notified at	by Funeral	11. Marital Status  1 X Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	13. Was Decedent of His If Yes, specify Cubar 1 ☐ Yes 2 ☑ No	spanic Origin? (Specify n, Mexican, Puerto Rica Specify:	Yes or No- an, etc.)	14. Rece - America Black, White, e Specify: whit	etc.
21215-0036	S = 3	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		6a. Decedent's Usual Occupa (Give kind of work done d life. DO NOT use retired)	luring most of working	unk 16b. K	ind of Business/Indi	<sup>lustry</sup> unk
	should be filed withing Mental Hygiene. marked other then matte event, the M	Be	17. Father's Name (First, Middle, Last)		unk	18. Mother's Name (Fi	et Klebe	Sumame)	
Maryland	s 1 and 2 should f Health and Men Item 27 is marke other traumatic	ဥ	19a. Informant's Name/Relationship (Type	pe, Print)	9b. Mailing Address (Street a			or Town, State, Zip	Code)
Baltimore, N	0 0		Marylnad Transitio  20a. Method of Disposition  1 Burial 2 Cremation 3 CR  4 Donation 5 Cother (Specify)	emoval from State 20b. Place	954 Forrest of Disposition (Name of stery, crematory or other place	Avenue Bal	timore, N	(1) 212(12 ocation - City or Tov	wn, Stete
Balti	permit. Page Department o Important: If sny injury or once.		21. Signature of Figner I Sprice Licen	1-1	State Anato Baltimore,	omy Board 6 MD 21201	555 W. Ba	ltimore S	treet
2	Physician		23a. Part 1 Enter the disease, or complishock or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	cations that caused the death. De cause on each line.	not enter the mode of dying				Approximate Interval Between Onset and Death
68760,	Medical Examiner bhysician and st the butial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, Disease or injury that initiated events resulting in death) Last	Due to (or as a consequent   18 (	ndoleSic	uency S	Grdrome	20 yr 20 yr	
Box 6	death certi e attending id for use a	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	ath 3 ☐Ectopic pregnancy			23d. Date of deliver Month	ry Day Year
rds, P.O	The law requires that the de ste has been signed by the a bage 2 should be detached l	þ	Part II. Other significant conditions cor	ntributing to death but not resultin	ng in the underlying cause give	en in Part I.		use contribute to the	e cause of death?
Il Records,		Completed					24a. Was an autopsy performed?	prior to com	psy findings available inpletion of cause of 2 No N/A
on of Vital	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate completely filled in by the funeral director, page	ıtlon; To Be	25. Was case referred to medical examiner?  1 X Yes 2 No  27. Manner of Death  1 X Natural 5 Pending investigation	lospital: 1 Inpatient 2 ER  28a. Date of Injury (Month, Day Yeer)  28	b. Time of 28c. Injury Work	4   Nursing Home		6 <b>X</b> Other (Specify	,Infirman
Division	al or Attendi s after death. Il Director: A d in by the fu	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	, farm, street, factory, office	28f.	Location (Street ar City or Town, State	nd Number or Rural e)	l Route Number,
	To the Hospital or Att within 24 hours after d To the Funerel Direct completely filled in by	Medical (		sician: To the best of my knowle ner: On the basis of examination and manner stated.					
	To th within To th	Me	29b. Signature and title of certifier	Kane MT	29c. License			ori (15	
			Marcia 4.7	empleted cause of death (Item 23	954 Fore	est Ave	Bat	Timore	MD.
	Sta Regist		31. Date filed (Month, Day, Year) APR 2 1 2005	92. Registrar's Signature	Soule				

	J KUVE		For State Registrar	State o	f Maryla		artment of H tificate of L		Mental Hy	giene Reg. No.	05	13543
			Decedent's Name (First, Middle, La	ıst)					2. Date of Dea	ath	V	3. Time of Death
н	Physici /Medic		Ursula Joan Ko	vacs					APRIL	$11, ^{0ay}20$	005	8:32 P M
,	Examin		4a. Facility Name (If not institution, git 3311 DORCESTER		mber)		4b. City, Town, or BALTIMOR		ath	4c. Cou	inty of Death	
П	Funeral Director			Sex 1 □ M 2 🔯 F	7. Age (In yrs	i. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Min		1933	9. Birtho Cour Mary	place (State or Foreign arry) and
	pu .		Usual Residence of Decedent  10a. State 10b. County		100.0	city, Town or Lo	cation				1	0d. Inside City Limits
	Aaryla I shov	ō	MD			Baltimon						1 <b>]</b> [7] Yes 2 □ No
	the A	Director	10e. Street and Number				10f. Zip Code			10g. Citizen	of What Cour	ntry?
	3a or	io ie	3311 Dorchester	Road			21	1215			USA	
ထ	2 should be filed within 72 hours after death with the Maryland and Mental Hyglene. is marked other than "natural", or Items 23s or 28s-f show aumatic avent, the Medical Examinar must be notified at	Funerai	11. Marital Status 1 □ Never Married 2 Married	12. Was Dec Armed Fo 1 _ Yes If Yes, Gi	2 📉 No	'	Was Decedent of Hi f Yes, specify Cuba I ☐ Yes 2X No	ispanic Origin? n, Mexican, Pue Specify:	(Specify Yes or No erto Rican, etc.)		Race - Americ Black, White,	
-003	2 hours a atural', c	ted by	3 Widowed 4 Divorced	Year or E	Dates:	16a. Deced	tent's Usual Occupa	ation	notine		ocify: WIN	
21215-0036	t within 7 liene. r than "n	Completed	(Specify only highest gi	College ( unk		life.	kind of work done of DO NOT use retired homen	)	rorking	OW	n home	
and	9 7 5	To Be C	17. Father's Name (First, Middle, Las Charles W. Foan						ame (First, Middle,		mame)	
10	es 1 and 2 should b of Health and Ment fitam 27 is markac r other traumatic a	-	19a. Informant's Name/Relationship Sandon Cohen/atto						Rural Route Number	_		
Baltimore,	Pages 1 and 2 nent of Health ant; If itam 27 i ury or other tra		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ 1 □ Donation 5 ☒ Other (Spec		State		sition (Name of natory or other plac		Date		on - City or To	
Baltin	permit, Pages Department of Important; If it any Injury or o				Directo	or S	Name and Addrest tate Anat altimore,	ss of Facility Omy Boa MD 21	rd 655 W.	Balt	imore S	Street
			23a. Part1. Enter the disease, or cor	nplications that	caused the de					rest,		Approximate
	Physician /Medical		shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a Ath	erusci		Cardio	vascu	lar dis	kse.		Interval Between Onset and Death
I	Examiner	L.	Sequentially list conditions, if any, leading to immediate	b	(or as a conse							
	acuted ind transit	Examiner	rr any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c								
8760,	cate be executed physician and s the burial-transit	dical Ex	Tosuling in death, Last	d	(or as a conse	equence on:						
ဖ	ertifica ding pt	/Med	IF FEMALE:	220 Hyes o	itcome of preg	nanov				204	D-1	
O. Box	at the death certific by the attending p stached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 XNo 9  Unknown	1 🗆 Live	birth 2 ☐ Fe nant at time of	tal death 3	Ectopic pregnancy Other (specify)		<del></del>	230.	Date of delive Month	ory Day Year
۳.	that the	y Ph	Part II. Other significant conditions	contributing to	death but not re	esulting in the u	nderlying cause give	en in Part I.	23e. Did t	obacco use	contribute to the	he cause of death?
ds	w requires that s been signed b should be deta	d by							1 🗆 '	∕es 2□N	o 3 ☐ Prob	oably 4 Unknown
Vital Records,	e la has ye 2	Completed								rmed?	prior to co death?	opsy findings available impletion of cause of
ta	ician: Th certificate rector, pag	a)	25. Was case referred to medical					26. Place of D	1 ☐ Yes Death (Check only o	ne)	1 🗆 Yes	2 No
<u> </u>	ysician: nis certific director,	To B	examiner? 1 X Yes 2 ☐ No	Hospital:	Inpatient 2	☐ ER/Outpatier	at 3 DOA Othe	er: 4 ☐ Nursing	Home 5 ☐ Resid	dence 6X	Other (Specif	y) SCENE
Division of	nding Ph ath. r: After th e funeral		27. Manner of Death  1 Natural 5 Pending 2 Accident investigati		of Injury oth, Day Year)	28b. Time of Injury	Worl	/ at k? Yes 2 □ No	28d. Describe	now injury oc	curred	
Divis	al or Atta after dec Diracto d in by th	Certification;	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	∠ 289. FIAC	e of Injury - At ling, etc. <i>(Spe</i> d	home, farm, str cify)	eet, factory, office		28f. Location (S City or Tox	Street and N vn, State)	umber or Rura	al Route Number,
	To the Hospital or Attanding Physician: within 24 hours after death. To the Funeral Director: After this certifics completely filled in by the funeral director,	edical C		miner: On the l					ice, and due to the courred at the time,			
ł	To the within To the comp	Me	29b. Signature and title of certifier	1110	24	9-	29c. License	e number			gned (Mo <i>nth</i> , L 12, 2	
			30. Name and address of person who	completed cau	ise of death (It	ет 23а) (Туре,		Penn Str	ceet Ral	timore	. Marv	land 21201
F8	Sta Registi		31. Date filed (Month, Day, Year) APR 2 1 20		Registrar's Sig	nature	E)		Jul Dal		y + **** y	- MANAGERIA

State of Maryland / Department of Health and Mental Hygiene) For State RegistreAMEND ITEM #5,10e&20b per fh 8842 4/21/05 JH 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** SYLVIA LAZEROW APRII <u> 2005</u> /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner UNION MEMORIAL HOSPITAL BALTIMORE N/A If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 03/01/1918 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. S**21 5003 N0490** 6. Sex **Funeral** Days Hours 1 ☐ M 2 🗖 F Months 87 MD Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Item 27 is marked other than "natural", or itams 23s or 28e-f show other traumatic event, the Medical Examinar must be notified at 1 ¥ Yes 2 □ No MD N/A BALTIMORE Director 10g. Citizen of What Country? 10e. Street and Number 830 W. 40th street 10f. Zip Code 830 40th STREET 21211 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 11. Marital Status 1 ☐ Never Married 2 ☐ Married Specify: WHITE 1 □ Yes 2 No Saltimore, Maryland 21215-0036 Specify: Completed by 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) ARTIST & WRITER ART & WRITING 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If Item 27 Is marked othe any injury or other traumatic event, once. 17. Father's Name (First, Middle, Last) BENJAMIN SUGAR ROSE HALPERT 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ALEXANDRA LAZEROW / DAUGHTER 2629 ROCKWOOD AVENUE BALTIMORE, MD 21215 20b. Place of Disposition (Name of HT4) Prematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State HILTOP SERVICE CORP. 04/20/2005 TOWSON, MD \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 < 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final CEREBROVASCULAR DISEASE 5 YRS **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner HYPERTENSION 10 YRS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit DIEBETES 15 YRS and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medical as the 23c. If yes, outcome of pregnancy 1□Live birth 2 □ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months?
1 ☐ Yes 2 ☐ No 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by filled in by the funeral director, page 2 should be 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown HYPERCHOLESTEROLOMA 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 X No this certificate has 1 Yes or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 2 1 Inpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 27. Manner of Death Certification: After 1 XNatural 5 Pending 1 Yes 2 No investigation 2 Accident within 24 hours after deatl To the Funerel Diractor: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only one) 29c. License number e of certifier 29b. Signate of death (Item 23a) (Type, Print) 30. Name and address of person who co 10753 Falls Good Sulo 200 Tinoth 31. Date filed APR DQ. State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

				State of Marylar				-	_	ible.	
			For State Registrar		Cei	rtificate of	Death	1	Reg. No.	0.5	13545
П	Physici	an	1. Decedent's Name (First, Middle, Last)  ALICE SEAL	LMCKEA	N			2. Date of De Month April	19,	2005	3. Time of Death  2:00 P M
	/Medic Examir		4a. Facility Name (If not institution, give s			4b. City, Town,	or Location of Deat		4c. Count		2.00 1
	Exami	ei	Paradise Assisted			Caton	sville		Bal	timore	5
П	Funeral		5. Social Security Number 6. Sex		last birthday) 3 Yrs.	If Under 1 Year Months Days		8. Date of Bir (Month, Da NOV • 4	rth ay, Year)	9. Birthpla Count	ace (State or Foreign y) Lana
	Director		578-16-6905		, , , , , , , , , , , , , , , , , , , ,			NOV. 4,	, 1911	Ind.	Laпа
	nyland how		10a. State 10b. County	10c. Cit	y, Town or Lo	ocation				10	d. Inside City Limits
	8e-f s	Director	Maryland Baltimore		Catons						1 ☐ Yes 2 XNo
	with the		10e. Street and Number			10f. Zip Code 21228	)		10g. Citizen of	What Counti	ry?
	ns 23	Funeral	6348 Frederick Road	2. Was Decedent Ever in U	.S. 13.		Hispanic Origin? (S can, Mexican, Puer	pecify Yes or No	USA 0- 14. Ra	ce - America	
9	or Iter		1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give	1	lt Yes, specify Cub 1 □ Yes 2🔯 No		to Rican, etc.)	Speci	ck, White, e	
003	within 72 hours after death with the Maryland ene. than "netural", or Items 23e or 28e-f show he Madigal Examiner must be notified at	d by	3 ☐ Widowed 4 ⚠ Divorced	Year or Dates:							
15-	d within 72 ho plene. r than "netur the Medical	plete	15. Decedent's Educ (Specify only highest grade	completed)	(Give	dent's Usual Occu kind of work done DO NOT use retire	e during most of wor ed)	rking	16b. Kind of E	gsiness/indi	istry
212		Completed	Elementary/Secondary (0-12)	College (1-4or 5+) 2	Но	memaker			Ow	n Home	9
pu	be filed a stal Hygie of other event, it	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nar			me)	
ryla	should be nd Mental marked c matic eve	ဥ	Flavian A. Seal  19a. Informant's Name/Relationship (Tyx)	ne. Print)	19b. Mailir	na Address (Stree	t and Number or Ru	E. Grave		. State. Zip (	Code)
Ma	nd 2 salth an 27 is r treu		Paul F. McKean, S			un Road	Relay,				,
ore,	es 1 a of Hea f Item r othe		20a. Method of Disposition 1 □ Burial 2X Cremation 3 □ Re		Place of Dispo emetery, crea	sition (Name of matory or other pla		Date	20c. Location	- City or Tow	n, State
Baltimore, Maryland 21215-0036	Pag tment tent: I jury o		`4 □Donation 5 □ Other (Specify)	M∈		ematory			Baltimo		
Bal	permit. Pages 1 and 2 should be Department of Health and Menta Importent: If Item 27 Is marked eny Injury or other treumatic er <u>QDCs</u> .		21. Signature of Funeral Service Ucense Thomas Gregor	H <del>O</del>	2	remation 99 Frede	ess of Facility N Society Prick Road	Of Mary d Baltin	land In	c. ryland	1 21228
П			23a. Part1. Enter the disease, or complic shock, or heart failure. List only on	cations that caused the deat e cause on each line.							Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	ARTERIOSO  Due to (or as a consec		TIC VA	SCULAR	DIS	EASE		
1	Examiner			•	dence or).						
	p #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq	uence of):						
	xecute and Il-trans	Examiner	that initiated events cresulting in death) Last	Due to (or as a conseq	uence of):						
760,	The law requires that the death certificate be executed tte has been signed by the attending physician and page 2 should be detached for use as the burial-transit	cal E	€ d		•						
68	rtificat ng phy as the		IF FOUND.								
Вох	ath ce ttendii or use	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregnation 1 ☐ Live birth 2 ☐ Feta	ıl death 3 [	Ectopic pregnance	<b>Э</b>			ite of deliver	y Day Year
P.O. I	that the de led by the a detached f	ysic	1 Yes 2 No	4□ Pregnant at time of c 9□ Unknown	leath 5L	Other (specify) _					
	res that igned by be deta	by Ph	Part II. Other significant conditions con	tributing to death but not res	ulting in the u	nderlying cause g	ven in Part I.	23e. Did 1	tobacco use con	tribute to the	cause of death?
ords	w require been sig should b	ted t	DEUTE COLO	RECTALH	EMOG	ZRHAGO	<u></u>	1 🗇	Yes 2 No	3 Proba	bly 4 Unknown
Records,	law r nas be e 2 sh	Completed						24a. Was		Were autops prior to com death?	sy findings available pletion of cause of
al			05.01					1 ☐ Yes	2X No		P No
Vital	Physiclen: this certific ral director,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	ospital: 1   Inpatient 2	ER/Outpatier	nt 3 DOA Ot	hor	ath <i>(Check only o</i> lome 5 ☐ Resi		ner (Specify)	Assisted Living
n of	ding Phys	J: L	27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury				how injury occu		
Division	tend leath lor: the	cati	2 Accident investigation 3 Suicide 6 Could not be	OR - Place of laive. At h	(		]Yes 2 □No	29f Location /	Street and Num	hor or Pural	Pouto Number
Divi	for Attencatter death Director:	Certification:	4 Homicide determined	28e. Place of Injury - At h building, etc. (Special	y)	eet, factory, office		City or To		Jer or Horar	riodia ridinoer,
	To the Hospitel or At within 24 hours after d To the Funerel Direct completely filled in by		29a. Certifier 12 Certifying Phys	ician: To the best of my known or: On the basis of examina	owledge, deati	h occurred at the t	ime, date and place	e, and due to the	cause(s) and m	anner as sta	ted.
	To the H within 24 To the F complete	Medical	29b. Signature and title of certifier	and manner stated.			se number		29d. Date signe		
ı	wit or	-	2 aurence	Realley	er, M		0178	6	APRIL		
	d		30. Name and address of person who con LAUREUCE R.	moleted cause of death (Iter	n 23a) (Type,	Print)	MAIDEN CI	10(C = 1 A	NE BA	LTO,	4021228
	Sta	te.	31. Date filed (Month, Day, Year)	32 Registrar's Signa	ature			p.N	7.0		
	Registr		APR 2 1 200		5. So	and					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- State of Maryland / Department of Health and Mental Hygiene State of Health and Mental Hygiene Certificate of Death

Reg. No. Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year **Phýsician** 2346 MARSH 2005 4a. Facility Name (If not institution, give street and number) /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Agnes Hospital Baltimore MD If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 1970 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Menth, Day) 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** 1 🔼 M 2 🗆 F 213-27-871 Director Usual Residence of Decedent Maryland 10c. City, Town or Location 10h County 10d. Inside City Limits 10a State in than "netural", or freme 23a or 28a-f show the Madical Examiner must be notified at Himon 1. Yes 2 □ No Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1213 13006 14 death 1 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 25 No If Yes, Give 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after a Department of Health and Mental Hygiene. Importent: if Item 27 is marked other than "netural", or Item any injury or other traumatic event, the Madical Exeminant ORGE. 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify BIAC 3 ☐ Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) IRV P 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be 2 IAR5 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sister Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Balt. \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Poneral Selvice I Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) EIGHT DAY( Physician neumonia /Medical Due to (or as a consequence of). Examiner nd Stack ALDS Sequentially list conditions, if any, leading to immediate causs. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consumence of). Hospitel or Attanding Physician: The law requires that the death certificate be executed Exami Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown cate has been signed by page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 No Nonknown Completed certificate has been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 212 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital: 1 Suppatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 1 Yes 2 No Certification: To 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this funeral di 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident Injury 5 Pending within 24 hours after death. To the Funerel Director: A 1 🗌 Yes 2 No investigation 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 59614 APR 11 2005

State Registrar 31. Date filed (Month, Day, Year) APR 2 1 2005

CHANDRA BOMMA, MD.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9100 2. Registrar's Signature

MARSH, DARRIN

CATON AVE,

BALTIMORE, MD

	1 - For State of Maryland / Depart Registrar Certif	tment of Health and M ificate of Death	lental Hygiene Reg. No	21115 1251.0
q	Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death
Physician /Medical	Mary Josephine McCarthy		APRIL 18	2005 2:40AM
Examiner	4a. Facility Name (If not institution, give street and number)  4	b. City, Town, or Location of Death		. County of Death
	SAINT TENES HEALHICATE	BALTIMORE		/A
Funeral	15 M 2 M 5	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
Director	217-16-8335 Yrs.		0ct. 13, 1	908 Maryland
aryland show	10a. State 10b. County 10c. City, Town or Local Maryland Baltimore Lansdowne	tion		10d. Inside City Limits
e Mar a-1 si	Maryland Baltimore Lansdowne			1 ☐ Yes 2 ☐ No
or 28	10e. Street and Number	10f. Zip Code	10g. Ci	tizen of What Country?
s 23a	2410 Brunswick Rd.	21227		U. S. A.  14. Race - American Indian,
iffer death with the Mar first must be notified first must be notified Funeral Director	1 Never Married 2 Married 1 Ves 2 ANO	is Decedent of Hispanic Origin? (Spe es, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White, etc.
036  ours after death with the Maryla Eran or Items 23a or 28a-1 show Eran or Items 23a or 28a-1 show In by Funeral Director		]Yes 2∯No <i>Specify:</i>		Specify: White
5-0 72 ho natur	15. Decedent's Education 16a. Deceder (Specify only highest grade completed) (Give kir.	nt's Usual Occupation and of work done during most of worki	16b. K	and of Business/Industry
21215-0036 ed within 72 hours aft sygiene netural, or it, the Medical Exam Completed by F	Elementary/Sacondary (0-12) College (1-4or 5+) Package	NOT use retired)		akery
Higher ther ther to Co	17. Father's Name (First, Middle, Last)		(First, Middle, Maiden	
y, Maryland 21215-0036  and 2 should be filed within 72 hours after death with the Maryland astith and Mental Hygiene.  n 27 is marked other than "natural", or Items 23a or 28a-1 show ner traumatic event, the Medical Erandar must be notified at To Be Completed by Funeral Director	Frank Persinger		th Heinlei	
shoul mid M mark	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing	Address (Street and Number or Rura	Al Route Number, City o	or Town, State, Zip Code)
Mand 2	Edward McCarthy, son 3612 N	Northway Dr. Bal	timore, MD	. 21234
Ores 13		tory or other place)		ocation - City or Town, State
Baltimore, permit. Pages 1 ar apparant of Hea my injury or othe my force.	'4 □Donation 5 □Other (Specify) Meadowridg	ge Memorial Park		Elkridge, MD
Baltimore, Maryland 21215-003 permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; any injury or other traumatic event, the Medical Example. To Be Completed by		dbrosê <sup>dd</sup> Funferdi Ho 119 Hammonds Ferr		
	23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.			Approximate Interval Between
Physician	Immediate Cause (Final disease or condition Lower GtsTRdINFE	STINAL BLEE	5	Onset and Death
/Medical Examiner	resulting in death)  Due to (or as a consequence of):			
1	Sequentially list conditions, if any leading to immediate b. Due to (or as a consequence of):			
o), executed an and rial-transit Examiner	Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events			
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ate ate	d			
X 6. sertition of the contract	IF FEMALE: 23c. If yes, outcome of pregnancy			
P.O. Box 6( nat the death certific d by the attending p letached for use as: Physiclan/Mec	in the past 12 months?	etopic pregnancy hther (specify)	Į,	23d. Date of delivery  Month Day Year
P.O. that the de by the detached	1 Yes 2 No 9 Unknown 9 Unknown	and (specify)		
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Cords  cords  w require been sig should b	Damentia		1 ☐ Yes 2	□ No 3 □ Probably 4 ★ Unknown
orthy, Mary, or or of Vital Records, g Physician. The law requires the this certificate has been signemental director, page 2 should be don; To Be Completed by			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
I Be cate he page			performed? 1⊠Yes 2□No	death? 1 Yes 2 No
of Vital F Physician: Th this certificate ral director, pag.	25. Was case referred to medical examiner?	26. Place of Death	-	
Of V Of V Physi rithis c ral dire	1 Tes 2 ER/Outpatient	3 DOA Other: 4 Nursing Hor	me 5 Residence 28d. Describe how injur	
Vision o' Vision o' Vision o' Attending Ph r death. ector: After th by the funeral	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation  28a. Date of Injury (Month, Day Year)  28b. Time of Injury	28c. Injury at Work?  M 1 □ Yes 2 □ No		,
Division of the or Attending Passer death all pirectors distributed in by the tunera certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, street building, etc. (Specify)	t, factory, office	28f. Location (Street an City or Town, State	d Number or Rural Route Number,
Div Div sate or rs atte or ral Divided in I	Dulluing, etc. (Specify)	4	ony or rown, orace	
Divi	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death or control one)  Medical Examiner: On the basis of examination and/or investigation and manner stated.			
To th withir To th comp	29b. Signature and title of certifier	29c. License number	29d. Da	te signed (Month, Day, Year)
	> 16 fled Vimne & The [7 W), Mis	P16705	APri	
10	30 Name and address of person who completed cause of death (Item 23a) (Type, Pri	AGNES HEALT	HCARE, P	ACTIMORE, MARTLAND
State Registrar	31. Date filed (Month, Day, Year). 32. Registrar Signature APR 2 1 2005	South		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 6.30 PM Month **Physician** -0 ovetta Murph /Medical 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner NWS: No Wellness Cent Rocky If Under 24 Hrs. 8. Potomae Valley 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, 5. Social Security Number 6. Sex Funeral Min Year) 1 M 2 F 90 12-09-1914 1280 14991 Director NY Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23s or 28s-f show the Wedical Exercises must be exittled at Rockville Montgomery MD 1 ☐ Yes 2 No Be Completed by Funeral Director 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 1235 Potomac Valley Road 20850 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc., 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: wite 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced american 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Buyer Dept. Store 8 0 .. Pages 1 and 2 should be filed witnent of Health and Mental Hygien tent: If item 27 is marked other thiury or other traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Eleanor Suchovicki William Michalak 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1235 Potomac Valley Road, Rockville, MD 20850 James R. Murphy / Husband 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☑ Removal from State Calvary Cemetery Johnson City NY Department of Important: If any injury or 8/05 ' 4 ☐ Donation 5 ☐ Other (Specify) Victor P. Doda, Jr. Charles L. Stevens runerar inches MD

1501 Fast Fort Avenue, Baltimore MD . Charles L. Stevens Funeral Home, Inc. 21. Storature o Euneral 21230 23a. Part1. Enter the disease, of Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a consequence of): /Medical **Examiner** Oronary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Be Completed by Physician/Medical Examiner burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Dav in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.O. ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2□ No 1 ☐ Yes 2 No 1 Yes funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Certification: To 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? After 1 Natural 5 Pending investigation after death.

Director: Af
d in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 3 🗀 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 T Homicide filled within 24 hours a To the Funeral E 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 20060036

Registrar

State

omac Valley Nursing

Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend items 10c d 16a b per fil 8842 45 and Men'd Hygiene

			1 - For State Registrar	State of Maryla		লাt ঔপভিষাতি বাবি ate of Death		ene . No. 2005	
	Dhusisi		Decedent's Name (First, Middle, La				2. Date of Death Month	Day Year	3. Time of Death
	Physici /Medi	cal	MITCHEL	_ W. MOO			04 /	7 2005	1330 M
	Examir	ner	4a. Facility Name (If not institution, girls 3802 OAV	AVE	4b. C	ty, Town, or Location of Dea		BALT.	
	Funeral		5. Social Security Number 6.5	Sex 7. Age (In yrs		der 1 Year   If Under 24 Hr	S. 8 Date of Righ	O. Riethe	place (State or Foreign
	Director		2111111	12M 2DF /8y	Yrs. Month	ns Days Hours Min	Month, Day, Y	786 Cour	mp
land.	Mo M		Usual Residence of Decedent  10a. State  10b. County	10c. C	ity, Town or Location	Baltimore		1	10d. Inside City Limits
N C	e-f shifted	ctor	mD Baltin	nore	B60+	Dailthiole	_		1 X Yes Z No
di di	or 28 De no	Dire	10e. Street and Number			Zip Code	10g	. Citizen of What Cour	ntry?
11215-0036 within 72 hours after death with the Maryland	ns 23e	Funeral Director	3802 Oak	12. Was Decedent Ever in L	1- 17W	2/207	Spanifu Vas er Ne	14. Race - Americ	can Indian
علود و	or Item	Fun	1 Never Married 2 Married	Armed Forces?	If Yes, s	pecify Cuban, Mexican, Pue	into Rican, etc.)	Black, White,	etc.
ZIZIS-UUSB d within 72 hours af	d Exal	Completed by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1 L Yes	2 No Specify:		Specify: 131.	ACK
2 2	"net	olete	15. Decedent's E (Specify only highest gr	ade completed)	16a. Decedent's U (Give kind of life. DO ND	work done during most of w	orking 16	b. Kind of Business/In	dustry
Z Z	giene.	omi	Elementary/Secondary (0-12)	College (1-4or 5+)		un	known		unknown
Maryland Z	and Mental Hygiene. is marked other ther	Be	17. Father's Name (First, Middle, Last	^ 1			ame (First, Middle, Ma	den Sumame)	
should	d Men narke natic	ပ	MITCHELL IV.  19a. Informant's Name/Relationship	Moore	10h Maille Add	Cher	ulynne S	temart	
_ c			Mitchell W Max	1 Forther	38 V O	K Auenus	Baltimore	ity or Town, State, Zip	12/1
- ע	of Health fitem 27 r other tr		20a. Method of Disposition		Place of Disposition (A	lame of r other place)		Location - City or To	own, State
Pages	artment o ortent: If injury or		1 ♥ Burial 2 □ Cremation 3 □ 14 □ Donation 5 □ Other (Special	JRemoval from State	ina Memon	al Park 4-	23-05	Battimere	$\mathcal{M}$
	Department of Health Importent: If item 27 any injury or other tr	1	21. Signature of Funeral Service Lice	rea	22. Name 8728	and Address of Facility V	hughne Grando Not	DIM MD	al Servicek 21132
			23a. Part1. Enter the disease, or com shock, or heart ailure. List only	plications that caused the dea one cause on each line.	th. Do not enter the m	ode of dying, with as cardia	ac or respiratory arrest		Approximate Interval Between
	rysician Medical		Immediate Cause (Final disease or condition resulting in death)	a conse	tive her	A failure			Onset and Death
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recute	and I-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a consec	ulu	•			1 wel
ificate be ex	ng physician and as the burial-transit			d 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	puerice or).	done			ele less
tificate	as the	ledicai		a.		Service Control			7000
The law requires that the death certificate be executed	attending for use	Physician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregn 1 Live birth 2 Feta		pregnancy		23d. Date of delive	*
he de	the a	ysic	1 Yes 2 No	4□Pregnant at time of o	death 5 Other	specify)		Month	Day Year
that the	ned by the		Part II. Other significant conditions of	contributing to death but not res	sulting in the underlying	cause given in Part I.	23e. Did tobac	co use contribute to th	ne cause of death?
The law requires t	been sign	ed by					1 ☐ Yes	2₽No 3□Prob	ably 4 Unknown
law re	has bee	Completed					24a. Was an autopsy	24b. Were auto	psy findings available mpletion of cause of
		Con					performed	2 death?	2 No
Physicien: TI	is certificate director, pag	o Be	25. Was case referred to medical examiner?	Hospital:		0.1	eath (Check only one)		
Phy	er this	$\vdash$	1 Yes 2 No 27. Manner of Death	28a. Date of Injury (Month, Day Year)	ER/Outpatient 3 1 1 28b. Time of	28c. Injury at Work?	Home 5 Residence		0
Attending	death. stor: After / the funer	atio	1 Natural 5 Pending investigation	NIA	Injury M	Work? 1 ☐ Yes 2 ☐ No	NI	4	
5	P F F	Certification:	3 Suicide 6 Could not b 4 Homicide determined	building, etc. (Special	ome, farm, street, factory)	ory, office	28f. Location (Stree City or Town, S		I Route Number,
Hospit	within 24 hours a  To the Funerel D  completely filled i	edicai (	29a. Certifier 1 Certifying Ph (Check only one) 2 Medicel Exer	ysician: To the best of my kno niner: On the basis of examina and manner stated.	wledge, death occurre	nd at the time, date and plac on, in my opinion, death occ	e, and due to the caus urred at the time, date	e(s) and manner as st and place, and due to	ated. the cause(s)
To the	within To the comple	Me	29b. Signature and title of certifier		2	9c. License number	29d.	Date signed (Month,	Day, Year)
			Hu	- W>		D0039016	04	1-17-03	5
	4		30. Name and address of person who	a star annual		2 3 . 5			
	Sta	to	31. Date filed (Month, Day, Year)	32. Poistrar's Signa	SON , MC	2 21204			
	Registra	100	APR 2.1	2005	K Socal				

		_ For	Please	<b>Fype or Prir</b> State of Ma							_	
		1 - State Registrar					tificate of			Reg. No	2000	13551
Physici /Medic		1. Decedent's Name (Firs SAMMIE		MCCULL	OUGH				2. Date of De Month	Da	y 200	3. Time of Death 6 12:30 PM
Examir		4a. Facility Name (If not in	stitution, give	street and number)	BALTI	mires		or Location of Dea	th	40	. County of De	ath
Funeral		5. Social Security Number			e (in yrs. lasi		If Under 1 Year	MORE If Under 24 Hrs		rth	N/A 9. Bi	rthplace (State or Foreign
Director		246-16-77 Usual Residence of Dece		XM 2□F	81	Yrs.	Months Days	Hours Min	. (Month, D. 07/18	ay, Year) 3 / 1 9	(	UTH CAROLIN
larylan show	<u>_</u>		County		ļ	Town or Loc						10d. Inside City Limits
death with the Maryland ms 23a or 28a-f show	Director	MD  10e. Street and Number	N/A			BAL'I	IMORE (	CITY		10a Cit	izen of What C	Yes 2 No
th with 23a or	a Di	916 MCK	EAN AT	ZENIIE			21:	217		US		ountry?
	Funeral	11. Marital Status		12. Was Decedent E Armed Forces?	Ever in U.S.	13. W	as Decedent of I	Hispanic Origin? (S ban, Mexican, Pue	Specify Yes or Norto Rican, etc.)		14. Race - Am Black, Wh	erican Indian,
	by F	1 Never Married 2	Married ivorced	1 ☐ Yes 2 ☐ ↑ If Yes, Give Year or Dates:	10	1	□ Yes 2√ Xo	Specify:	,		Specify: BI	
	eted	15. D	ecedent's Edu y highest grad	ication	1	16a. Decede	ent's Usual Occup	pation	orkina	16b. K	ind of Business	
within ene. than "	Completed	Elementary/Secondary		College (1-4or 5	+)		O NOT use retire SHOREMA	during most of world)		СШБ	AMSHII	
filed Hygid other	Be Co	17. Father's Name (First,	Middle, Last)	<u> </u>		DONG	SHOKEMA		me (First, Middle			TRADERS
Menta Menta arked atic ev	To B	SAMMI	E MCC	CULLOUGH				JAN	IE WII	SON		
d 2 shoth and 7 is m		19a. Informant's Name/Re						and Number or R				,
ges 1 and 2 should be filed within 72 h it of Health and Mental Hygiene. If item 27 is marked other than "natu or other traumatic event, the Medical		INEZ H. Mo		OUGH / W.	IFE 20b. Place	e of Disposi	tion (Name of	N AVENU	E, BALT	20c. Lo	RE, MI	21217 Town, State
Page: nent o ant: If ury or		1 ☑ Burial 2 ☐ Cren `4 ☐ Donation 5 ☐ C				-	atory or other pla MEM。PA	ARK 4/2	3/2005			E CO., MD
permit. Pages 1 and 2 should be filed within popartment of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, ITEM ODGS.		21. Signature	Service Licens	ee A		22.	Name and Addre	ess of Facility	HOWELL	FUN	ERAL H	IOME 21207
405 60		23a. Part Enter the dise	ease, or compl	ications that caused	the death			BERTY HI			, BALI	IMORE, MD
Physician		shock, of hear failur Immediate Cause (Final disease or condition	re. List only or	ne cause on each lin	no.	ANC		ng, saon as cardia	o or respiratory a	1103(,		Interval Between Onset and Death
/Medical Examiner		resulting in death)		Due to (or as a	a consequen	-	CIC					x weeks
Lammer	ē	Sequentially list conditions if any, leading to immedia	s, t	Due to (or as a	a consequen	ce of):						
executed in and ial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	~ ~ .		, , , , , , , , , , , , , , , , , , , ,	,.						
e be executed sician and e burial-transit	al Exa	resulting in death) Last		Due to (or as a	consequen	ce of):						
tificate b ng physic as the b	dica			d								
eath certificat attending phy for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregn	ant 2	3c. If yes, outcome (						2	23d. Date of de	livery
es that the death certigned by the attendin be detached for use	sicia	in the past 12 month 1 ☐ Yes 2 📆 😘 9 ☐ Unknown	9?	1□Live birth 4□Pregnant at 9□ Unknown			ctopic pregnancy Other (specify)	y 			Month	Day Year
that the ed by detach	/ Phy	Part II. Other significant of	onditions cor	ntributing to death bu	it not resultin	a in the und	leriving cause giv	ren in Part I.	23e, Did t	obacco u	se contribute to	the cause of death?
quires in sign	ed by									es 2[		robably 4 Unknown
ie law requir has been si ge 2 should	Completed								24a. Was		24b. Were at	utopsy findings available completion of cause of
ician: The certificate h rector, page									perfo	rmed?	death?	2 No
ysician: The lis certificate hadirector, page	o Be	25. Was case referred to rexaminer?	_	lospital:		Outpatient	3□ DOA Oth	or	ath (Check only o			
ng Phy ter this neral o	n: To	27. Manner of Death	Dandina	28a. Date of Injun (Month, Day		b. Time of Injury	3 DOA 28c. Injur	4 🗀 Nursing r	lome 5 Resident			cify)
tendir leath. tor: Af the fur	ertification:	2 Accident	Pending investigation Could not be				M 1 🗆	Yes 2 □ No				
after of Direct of Jin by	ertifi	4 Homicide	determined	28e. Place of Inju building, etc.	ry - At home, . <i>(Specify)</i>	, farm, stree	t, factory, office		28f. Location (S City or Tov			ural Route Number,
E S E S	Medical C	29a. Certifier 1 C (Check only one)	ertifying Phys	sician: To the best o	examination	dge, death o and/or inve	occurred at the tir stigation, in my o	me, date and place	e, and due to the	cause(s) date and	and manner as	stated.
ro the vithin 2 on the comple	Med	29b. Signature and title of		and manner stat			29c. Licens				signed (Mont	
0		DPur	ohit	- MB	B-5	Š	RE	5-00		APA		9,2005
0		30. Name and address of p		mpleted cause of de	ath (Item 23	a) (Type, Pr	int)	21				
() Stat	e	Javs ho		TUVO h	r's Signature	MB	- 135 5	SINAI F	LOSPITA	tL_	OF B	ALTIMORE
Registra	_		1 2005	Marie	Jr.	good						

		•	For State Registrar	State of	Maryland		artment of H			iene <sub>eg. No.</sub> 200	5 1355	2
	Physici		Decedent's Name (First, Middle, L.)	ast) Virg	ginia L.	. Mile	s		2. Date of Deat		10 30 /14	
)	/Medic Examin	_	4a. Facility Name (If not institution, g 800 Southerly Re	J	ber) nwald)		4b. City, Town, or Towson	Location of Death	1	4c. County of D	Death	
	Funeral Director		212-48-6843		. Age (In yrs. Ia 100	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Sept 4,	Year) 9. 1904 A]	Birthplace (State or Foreign Country) Labama	_
	show	'n	Usual Residence of Decedent	more	10c. City	Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 📉 Xo	
	with the N a or 28e-f be notified	Direct	10e. Street and Number			No.	10f. Zip Code		1	0g. Citizen of What	t Country?	
36	be filed within 72 hours after death with the Maryland at Hygiene. I all Hygiene. I cher than "netural", or Items 23a or 28e-f show dother than "netural", or Items 23a or 28e-f show event, the Medical Examinar must be notified at	by Funeral Director	800 Southerly Ro.  11. Marital Status  1 Never Married 2 Married  3 November 4 Divorced	12. Was Deced	2 <b>)(</b> ) <b>(</b> )(0		2128 Was Decedent of Hi f Yes, specify Cuba  □ Yes 2 No		pecify Yes or No- o Rican, etc.)		American Indian, White, etc. White	
Baltimore, Maryland 21215-0036	i within 72 hou jene. r than "neture the Medical E	Completed	15. Decedent's (Specify only highest g		4or 5+)	(Give life.	dent's Usual Occupa kind of work done o DO NOT use retired	luring most of wor )	king	16b. Kind of Busine	ess/Industry Firm	
land ?	d ta b	To Be C	17. Father's Name (First, Middle, La.	Lovi	ick P. I				ne <i>(First, Middle, I</i> Jones	Maiden Sumame)		
, Mary	I and 2 shou lealth and M om 27 is ma ther trauma		19a. Informant's Name/Relationship John Miles (Son				ng Address (Street a Elm Aver			, City or Town, Stat ID 21227	te, Zip Code)	
more	Pages nent of h ant: If ite ary or of		20a. Method of Disposition  1 Burial 2 Cremation 3  4 Donation 5 Other (Special Control of Control	□Removal from S		ace of Dispo imetery, crei 1to/Wa	sition (Name of natory or other place sh Cremat	e) cory 4/2		20c. Location - City Laure1, N		
Balt	permit. Pag Department Importent: I any injury o		21. Signature of Funeral pervice	Cang	sent	36	31 Falls	Road F	Balto, MD		1	
Ĺ	cate be executed by Sician and Medical Examples of the private stranger of the	dical Examiner	23a. Part1. Enter the disease, or conshock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (c	or as a consequent or	ence of):			or respiratory arri	est,	Approximate Interval Between Onset and Death	<b>(</b>
O. Box 68	The law requires that the death certificate be executed tite has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		rth 2 ☐ Fetal ant at time of de	death 3[	Ectopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year	
۵.	uires that t signed by Id be detai		Part II. Other significant conditions	s contributing to de	ath but not resu	ilting in the u	nderlying cause give	en in Part I.			te to the cause of death?  Probably 4 Minknown	
al Recor	i: The law require icate has been si ; page 2 should b	Completed								prior death	e autopsy findings available to completion of cause of h? Yes 2 \sumbox No	
Division of Vital Records,	To the Hospital or Atlending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	tion: To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death 1 Actival 5 Pending investigat	28a. Date o (Monti		ER/Outpatier 28b. Time o Injury	28c. Injun Work	er: 4 □ Nursing H		ence 6 □Other (S ow injury occurred	Specify)	
Divis	al or Attendi safter death. I Director: A id in by the fu	Certification;	3 ☐ Suicide 6 ☐ Could not determine	200. Flace	of Injury - At hor g, etc. (Specify	me, farm, sti	eet, factory, office		28f. Location (St City or Town		r Rural Route Number,	
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medical (			sis of examinati					ause(s) and manne ate and place, and	or as stated. due to the cause(s)	
	To t To t	Σ	29b. Signature and title of certifier	Paris			29c. License		2	9d. Date signed (M	onth, Day, Year)	_
	12		30. Name and address of person wh	no completed cause	of death (Item	23а) (Туре,				17	021091	_
	Sta Registi		31. Date filed (Month, Day, Year)	2 1 2005	egistrads Signat	turd	8 CAVO P	תמיות_	n Rum	n, Lini	THOUS	-

DHMH 17 Rev 1/2001

State Registrar LING

LI

31. Date filed (Month, Day, Year) APR 2 1 2005

32. Resistrar's Signature

111 Penn Street

Baltimore, Maryland 21201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

miD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** April 19, 2005 11:30 P<sup>M</sup> LORENE DOROTHY WOLF MURPHY /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Baltimore County OAK CREST VILLAGE CARE CENTER Parkville If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Date of Birth (Month, Day, Year) 1□M 2□F Months Days Hours Yrs. Director 89 216-10-5497 Feb 14, 1916 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits item 27 la marked other than "natural", or Items 23a or 28a-f ahow other traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 ☑ No Director Maryland Baltimore County Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8832 Walther Boulevard 21234 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ M No If Yes, Give <sup>1</sup>X Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: White 3 ₩ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Own Residence Homemaker 9th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Harry D Wolf Caroline 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 le any injury or other trai once. (Son) 200 Register Avenue, Baltimore, Maryland 21212 Thomas D. Murphy Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) New Cathedral Cemetery 4/23/2005 Baltimore, Maryland 21. Signatury Funer Sirvic (69) auso Mitchell-Wiedefeld Funeral Home, Inc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximately Care (First) Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Arterioscientic cardiovascular **Physician** /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (ur as a consequence of) Due to (or as a consequence of): Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, Unknown 1 Yes 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 ☐ No 1 Tes 25. Was case referred to medical 26. Place of Death Check onl one examiner? 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Cther: Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 27. Manner of Death
Natural
Accident 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Division 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 24 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

25643 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bud/Balto 10 8800 Walther State APR 21 Registrar 2005

			For State Registrar	ate of Maryla		partment of Fertificate of		Reg	ene . No D D D	1350
	Physicia		1. Decedent's Name (First, Middle, Last)  Marilyn G	lenn Nie	buhr	-		2. Date of Death Month	Day Year / 9 200 !	3. Time of Dedition
	/Medic Examin		4a. Facility Name (If not institution, give stree	t and number)		4b. City, Town, o	or Location of Death		4c. County of Dea	th
			ST. AGNES HO			BALT	THORE		N/	
	Funeral Director		5. Social Security Number 122-26-3360 6. Sex	o Wr	rs. last birthda <sub>.</sub> 76 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y DEC 13.	9. Bir 1928	thplace (State or Foreign ountry)
ı			Usual Residence of Decedent		70			JEC 13, .	1940	Indiana
	rylan show	_	10a. State 10b. County	10c.	City, Town or	Location				10d. Inside City Limits
	8a-f s	ecto	Maryland Carroll				minster			1 ☐ Yes 2 No
	with ti	Dire	10e. Street and Number			10f. Zip Code	0	109	. Citizen of What C	ountry?
	Jeath ms 23	Funeral Director	1502 Chris Lane	Vas Decedent Ever in	U.S. 13	2115 Was Decedent of F	് Hispanic Origin? (Spec an, Mexican, Puerto R	cify Yes or No-	USA 14. Race - Am	
ď	after o		1 Never Married 2 Married	Armed Forces?  ☐ Yes 2 XNo		If Yes, specify Cub 1 ☐ Yes 2 ☑ No		lican, etc.)	Black, Whi	
Š	nours ural',	d by	3 Widowed 4 MDivorced	Yes, Give Year or Dates:						White
4	n 72 h	Completed	15. Decedent's Education (Specify only highest grade con	npleted)	(Giv	edent's Usual Occup ve kind of work done  DO NOT use retire	during most of working	g 16	b. Kind of Business	/Industry
2	withi jiene. r then	ошь	Elementary/Secondary (0-12)	College (1-4or 5+) 2	Admi	nistrativ	e Assistan	t	Medical	
7	al Hyg	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Name		iden Sumame)	
ACOO ALCAC Landing	yid could be Ment Marked Marked	To	Gaskell Masters					Crawford		
Š	Wich d 2 sh th and 7 is m treum		19a. Informant's Name/Relationship (Type, I Scott Niebuhr/Son	rint)		lling Address (Street 2 Chris La	and Number or Rural	inster, l	*	Zip Code)
-	tem 2		20a. Method of Disposition	200		position (Name of ematory or other pla			c. Location - City or	Town, State
	Pages ent of nt: If i		1 ☐ Burial 2 XCremation 3 ☐ Remo 1 ☐ Donation 5 ☐ Other (Specify)				Inc. $4/20$	/05	Baltimor	e. MD
	Desitifficion (e.g., Mary yialing Z.I.Z.13-0030) permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. In Internated to the then "natural", or Items 23e or 28e-f show any injury or other treumatic event, the Medical Examination and the notified at once.		21. Signature of Funeral S. rvice Lipensee	11-		22. Name and Addre	ass of Facility			o, 120
0	0 505 50		Edward A. Gregor			remation 199 Freder	Society of ick Road B	MD, Inc altimore	MD 2122	28
			23a. Part1. Enter the disease, or complication shock, or heart failure. List only one can	use on each line.	eath. Do not e	nter the mode of dyi	ng, such as cardiac or	respiratory arrest		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	MINIS		orba	- FALL	-41/2		24 Huns
	Examiner			SF/S1						8 DAYS
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a cons						3.73
By	cuted nd ransit	Examiner	that initiated events	SMALL	Bun	hl	OBSTRUC	Tion		10 DAYS
7 8	ite be executed sysician and ne burial-transit		resulting in death) Last	Due to (or as a cons	sequence of):					
C		dical	d							
36	th certifica ending ph	an/Me	230. Was decedent pregnant	f yes, outcome of pre I □ Live birth 2 □ F		□Ectopic pregnanc	v		23d. Date of de	
El	15, F.O. BOX OC res that the death certifics igned by the attending ph be detached for use as t	Physician/Med	In the past 12 months?	4□Pregnant at time o 9□Unknown		Other (specify)	,		Month	Day Year
>	Ords, Frequires that	by	Part II. Other significant conditions contribu	uting to death but not	resulting in the	underlying cause giv	ven in Part I.		cco use contribute to	o the cause of death?
	2 0 10	letec		010				24a. Was an		utopsy findings available
7	DIVISION OF VITAL REC.  To the Hospital or Attending Physician: The taw within 24 hours after death.  To the Funeral Director: After this certificate has b completely filled in by the tuneral director, page 2 si	Completed						autopsy performe	d? prior to death?	completion of cause of
>	VILA icien: sertific ector,	Be	25. Was case referred a medical examiner?	itali		C#	26. Place of Death			
1	Physic rthis or ral dir	. To	1 1 102 5 140	1 lightnpatient 2	28b. Time	ent 3 DOA		e 5 Residence  3d. Describe how	ce 6 □Other (Spe	ecify)
8	ding th. : After s tune	atlon	1 Natural 5 Pending 2 Accident investigation	8a. Date of Injury (Month, Day Year	) Injury	Wo	rk? ]Yes 2 □No		,,	
T.	DIVISION  I or Attending after death. Director: After din by the function	Certification:	2 Could not be	Be. Place of Injury - A building, etc. (Spe	t home, farm,	street, factory, office	2	Bf. Location (Stree City or Town, S	et and Number or R State)	ural Route Number,
2	oitel or urs aft rel Di	Cer								
	e Hosp 24 ho e Fune letely fi	edical	29a. Certifier (Check only one)  1 Certifying Physicia 2 Medical Examiner:	<ul> <li>In: To the best of my to On the basis of examand manner stated.</li> </ul>	knowledge, de ination and/or	ath occurred at the ti investigation, in my o	me, date and place, ar opinion, death occurre	nd due to the caus d at the time, date	se(s) and manner a and place, and du	s stated. e to the cause(s)
	To th Within To th compl	Me	29b. Signature and title of certifier			29c. Licens		29d	. Date signed (Mon	2 -
	/\		1/2: Grevian	M.D.			50134	AI	mll 2	0 2005
	4		30. Name and address of person who complete the complete	eted cause of death (I	tem 23a) (Typ	e, Print)	BALT	Morh	MO 7	1227
	Sta		31. Date filed (Month, Day, Year)	22. Registrar's Si	gnature	and a				
	Registr	al .	APR 2 1 2005	Alexander A	r 1300					

			For	partment of Health and M ertificate of Death	Reg. N	2005	13557
	Physic	an	1. Decedent's Name (First, Middle, Last)	NELSON	2. Date of Death Month D APRIL 18	2005	3. Time of Death  9:45 A M
	/Media	cal	GOLDIE  4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	9.40 A
	Examin	iei	HOSPICE OF BALTIMORE GILCHRIST CTR.			BALTIN	
	Funeral Director		5. Social Security Number 6. Sex 212-07-7367 1 M 2 M F 7. Age (In yrs. last birthd	Months Davs Hours Min.	8. Date of Birth (Month, Day, Yea 08/28/191	9. Birthpla Count	ace (State or Foreign ry) MD
	aryland show		Usual Residence of Decedent         10a. State         10b. County         10c. City, Town or	Location	-	10	d. Inside City Limits
	r 28a-f show	ctor	MD BALTIMORE OWINGS				1 Tyes 2 No
	ath with th	Dire	4730 ATRIUM CT. APT. #207	10f. Zip Code 21117		Citizen of What Count	ry :
	er dea Items	Funeral Director	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Married 1 Yes 2 70 No	13. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto		14. Race - America Black, White, s	itc.
	21215-0036 of within 72 hours aft giene. er then "natural; or the Medical Exami	Completed by	3 X Widowed 4 □ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 No Specify:	16h	Specify: WITT	
	21215-0 s within 72 ho liene. r then "natui	plete	(Specify only highest grade completed) (G	Rive kind of work done during most of worki le. DO NOT use retired)	ing Tob.	Talle of Bushings in a	uotiy
	212 212 ad with rgiene er the	Com	12	HOMEMAKER	45	OWN HOME	
	Maryland 27 d 2 should be filed w th and Mental Hygie 77 is marked other it treumatic event. It	Be	17. Father's Name (First, Middle, Last)  NATHAN  G(	DLDSTEIN ANNA	e (First, Middle, Maid		RANOFSKY
	should Me mark	2		ailing Address (Street and Number or Rura	al Route Number, Cit		
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2 h	Baltimore, permit. Pages 1 a Department of Hee Important: If item any injury or otherence.		20a. Method of Disposition  1 \( \Delta \) Burial 2 \( \Delta \) Cremation 3 \( \Delta \) Removal from State  4 \( \Delta \) Donation 5 \( \Delta \) Other (Specify)	Manapy Piere 平44 <sup>e)</sup> CONG. 04/20	0/2005 RO	SEDALE MI	)
935 Am	Baltimo permit. Pages Department of Important: If i any injury or once.		21. Signature of Funeral Service Licensee	22. Name and Address of Facility SOL 8900 REISTERSTOWN F			
10			23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.			7	Approximate Interval Between
5	Pnysician		Immediate Cause (Final disease or condition			- 1	Onset and Death
8	/Medical Examiner		Due to (or as a consequence of)			(	Necla
-	Gall I	Je.	Sequentially list conditions, if any, leading to immediate  b. Due to (or is a consequence of)				
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3	ords, P.O.	by	Part II. Other significant conditions contributing to death but not resulting in the	ne underlying cause given in Part I.	23e. Did tobacc	co use contribute to th	e cause of death?
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	Division To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm building, etc. (Specify)		28f. Location (Street City or Town, St	t and Number or Rura tate)	l Route Number,
	Hospitel 24 hours a Funerel	edical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, (2 Medical Examiner: On the basis of examination and/and manner stated.	death occurred at the time, date and place, or investigation, in my opinion, death occur	and due to the cause red at the time, date	e(s) and manner as st and place, and due to	ated. the cause(s)
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	.1.		30. Name and address of person who completed cause of death (Item 23a) (T	ype. Print) Chanles St Bull	timens	wn 212	24
	S	tate	31. Date filed (Month, Day, Year)  32. Registrar's Signature				-
	Regis	trar	31. Date filed (Month, Day, Year)  APR 2 1 2005  32. Registrar's Signature	porte			

		Decedent's Name (First, Middle,			149/US JE	<b>!</b>	2. Date of Dea Month	Day	Year	3. Time of Death
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ector	-	579-40-9366	1□M 2□F XX	73 Yrs.	Months Days	Hours Mi	Dec 12			y Jersey
**	-	Usuel Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	ocation				100	d. Inside City Limits
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3	Director		220-96-6480	1 M 2 □ F	37	7 Yrs.	Months	Days	Hours	Min.	JUN 10	ay, Year) • 196	7 1	Count Marv	ace (State o ry) 1and	
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			30. Name and address of person who			23a) (Type,	Print)	11 F	enn '	Stro	et Bal	Itimo	re M	[arvi	and 2	1 201
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 1 tem 1 per phys 9843 5-18-05 vt.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last)
Arshad Pervez 2. Date of Death 3. Time of Death Parvez Month **Physician** 1012 PM Cepre 2005 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Hay Der Chesapeake Medical len If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 02/20/1950 6. Sex 7. Age (In yrs. last birthday) al Security Number 9. Birthplace (State or Foreign **Funeral** Pakistan Min 1**₽**₩ 2□F Months Days Hours 55 280-74-9484 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐Yes 2 ☐ No Director OH Wood Perrysburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 396 Rutledge Court 43551 USA items 23a Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 72 hours after ☐ Yes 2.XXIIIo 1 Never Married 2XXMarried ō 1 ☐ Yes 2XXNo Specify: Asian 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry is 1 and 2 should ba filed within of Health and Mental Hygiene. Item 27 is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) 5+ Chemist Medical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Bilgis Jehan Begum Hamid Hasan Khan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 s ment of Health an ant: If item 27 Is Yasmin Parvez / Wife 396 Rutledge Ct., Perrysburg OH 43551 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Highland Memorial Gardens 4/16/2005 Waterville, OH 1 ☐ Burial 2 ☐ Cremation 3 ☐ moval from State ō parmit. Page Department of Important: If any injury or once. 4 □ Donation 5 □ Other (Specify) Doda, Jr 22. Name and Address of Facility
Charles L. Stevens Funeral Home, 21. Signature of Funeral Service LicenseeVictor P. Inc. 21230 1501 E. Fort Ave., Baltimore MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit The law raquires that the death cartificate be executed Due to (or as a consequence of): Physician/Medicai the l IF FEMALE: usa 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) be detached 9 Unknown signad by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by None 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Be Completed funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an 2**X** No certificate 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 □ No Certification: To Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No death. 2 Accident fillad in by the Director: 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 24 hours a Funeral [ t Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier within 24 hor To the Fune completely fi (Check only one)

Division of Vital Records,

M800436155

Baltimore, Maryland 21215-0036

State Registrar

29b. Signature and title of certifier

man 30. Name and address of person

MA 32. Registrar's agnature

leted cause of death (Item 23a) (Type, Print)

and manner stated

**ORIGINAL** 

HOLABIRD AVE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.-2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Vaar **Physician** 14:59 pM 2000 /Medical 4b. City, Town, or Location of Death 4c. County of Death Eacility Name (If not institution, give street and number) Examiner Johns tospitia 7. Age (In yrs. last birthday)
3.5 Yrs. If Under 1 Birthplace (State or Foreign 5. Social Security Number **Funeral** Months Hours 1 № 2 □ F 267-67-2116 lori **Director** Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State or Items 23e or 28e-f show the Medical Evantiner must be notified at 1 **2** es 2 □ No Completed by Funeral Director Mich (senes 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code 4850 37 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 25 No Specify Black 3 ☐ Widowed 4 ☐ Divorced "neturel", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Worked 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be nent of Health and Mental I soft: If item 27 is marked o 00 ္ရ 19b. Mailing A. dress (Street and Number or Rural Route Num., er, City or Town, State, Zip Code) 19a. Informant's Name/Relationship other 20b. Place of Disposition (Name of cemetery, crematory or other pla Date 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2 Scremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ö Department of Importent: If eny injury or once. ¹ 4 ☐ Donation Name and Addre 21. Signature of Funeral Service Licenses Gr 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Days Pnysician a INtercornial disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Mtarciranial Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit Spi to Due to ( as a consequence of Box 68760. attending physician Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? ŏ 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. 1 ed by the a detached f 9 Unknown 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Completed by 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No cate has been sig , page 2 should b 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed certificate 2 No 26. Place of Death (Check only one) Hospitel or Attending Physicien: 25. Was case referred to medical examiner? Hospital Other: 1 🗌 Yes 1 Dunpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 2 this 28c. Injury at Work? 27. Manner of D ath Date of Injury (Month, Day 28d. Describe how injury occurred 28b. Time of After t Certification: 1 Salatural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. Director: 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) after 4 \ Homicide within 24 hours a To the Funerel C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) Medical completely To the I 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier April 12,2005

Registrar DHMH 17 Rev 1/2001

State

+aug burn

JENNIFER

31. Date filed (Month, Day, Year) APR 2 1

Name and address of person who completed cause of death (Item 23a) (Type, Print)

C. HUFFHAN

2005

600N . WOLFE ST

32 Registrar's Signature

T1003

BATIMGRE, HD 2/287

Pn /\ Ex

Division of Vital Records, P.O. Box 68760,

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygione.

		For State Registrer		State of Ma	aryland		irtment of H tificate of L			giene Reg. No.		
Diversity is			ne (First, Middle, Las	it)					2. Date of Dea	76	Vodr	3. Time of Death
Physici /Medic		JAMES PE	NN						APRIL		Year OOS	6:08PM
Examin		4a. Facility Name (	If not institution, give	street and number)				Location of Death		4c. County	of Death	
			SAMARIT		PITA		BALTII If Under 1 Year	MORE  If Under 24 Hrs.	1		N/A	
Funeral Director		5. Social Security N 217 18 97	42	7. Ag	e (In yrs. las 83	Yrs.	Months Days	Hours Min.	8. Date of Birt FEB • 9	1922	9. Birthp	place (State or Foreign
and w		Usual Residence o 10a. State	10b. County		10c. City, 7	Town or Loc	cation				1	0d. Inside City Limits
Many f sho	tor	MD	N/A		BALT:	IMORE						1 XYes 2 ☐ No
r 28a	Director	10e. Street and Nu	ımber				10f. Zip Code			10g. Citizen of W	√hat Coun	ntry?
fh wit	aiD	5402 WAB	ASH AVE.				21215		τ	J.S.A.		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Menfal Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic avant, ILe Modical Exantment institution and once.	Funeral	11. Marital Status 1 □ Never Marr	ried 2□ Married	12. Was Decedent Armed Forces? 1X Yes 2 1			Vas Decedent of Hi Yes, specify Cuba			14. Race Blac	k, White,	can Indian, etc.
ural',	d by	3X Widowed		Year or Dates:			Yes 2 No	Specify:		Specify.	BLAC	CK
"nati	Completed	(Spec	<ol> <li>Decedent's Ed cify only highest gra</li> </ol>			(Give I	ent's Usual Occupa kind of work done o OO NOT use retired,	luring most of work	king	16b. Kind of Bu	siness/Inc	dustry
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2 sho and 1 Is me			lame/Relationship (7				g Address (Street a			-		
and lealth m 27 her tr			PENN (GRAI	ND SON)	-		VABASH AV					
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f. Pa rtmen rtant: rjury			5 Other (Specify		MOODI		CEMETERY					E, MARYLAND
Depar Depar Impo		Dein	uneral Service Licen	1 dre	LSON	<b>1</b> 41	L2 E. PRE	STON STRI	EET BALI	IMORE, I		ERAL HOME LAND 21213
		23a. Part1. Enter t shock, or hea	the disease, or comp art failure. List only	olications that caused one cause on each lin	the death.	Do not ente	r the mode of dying	g, such as cardiac	or respiratory ar	rest,		Approximate Interval Between
Physician		Immediate Cause disease or condition	on	* 2E	PSIS	5						Onset and Death
/Medical Examiner		resulting in death)		Due to (or as	a consequer	nce of):						
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ufed .nsit	Examiner	cause. Enter Under Cause (Disease or that initiated events	ariving	200 10 (0: 20	2 0011004201	100 017.						
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rificate be execufed ng physician and as fhe burial-fransit	ledicai			d								
± og e		IF FEMALE:										
To the Hospital or Attanding Physician: The law requires final fihe death cerwithin 24 hours after death. To the Funaral Diractor: Affer this certificate has been signed by fihe affendin completely filled in by fihe funeral director, page 2 should be defached for use	Physician/	23b. Was deceden in the past 12 1 Yes 2 9 Unknown	! months?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal de	eath 3 🔲	Ectopic pregnancy Other (specify)			23d. Date Mon	of delive	ery Day Year
that f		Part II. Other signi	ficant conditions or	ontributing to death be	ut not resultir	ng in the un	derlying cause give	n in Part I.	23e. Did to	bacco use contri	bute to th	e cause of death?
w requires that the death been signed by the affe should be defached for	ted by	DEME							1 🗆 Y	es 2 No	3 🗌 Proba	ably Unknown
Physician: The law this certificate has b al director, page 2 st	Completed	HYPER	RTENSIC	N					24a. Was a autop: perfor	sy pi med? de	Vere autoprior to coneath?	osy findings available inpletion of cause of
sian: artifica ctor, I	Bec	25. Was case refer examiner?	rred to medical					26. Place of Deat				
hysic his ce il dire	10	-1 ☐ Yes 32	140	Hospital: Inpatie	nt 2□ER	VOutpatient	3□ DOA Othe	r: 4 🗌 Nursing Ho	ome 5 🗆 Resid	ence 6 🗆 Othe	r (Specify	)
inding Phath. r: Affer the funeral	Certification;	27. Manner of Deat  Natural  2 \( \text{Accident} \)	th 5 Pending investigation	28a. Date of Injur (Month, Day		Bb. Time of Injury	28c. Injury Work	at ? ′es 2 □ No	28d. Describe h	ow injury occurre	ıd	
e Hospital or Attandi 24 hours after death. 9 Funaral Diractor: A etely filled in by fhe fu	rtiffe	3 ☐ Suicide 4 ☐ Homicide	6 🗌 Could not be determined	28e. Place of Injubuliding, etc	ry - At home :. (Specify)	e, farm, stre	et, factory, office		28f. Location (S City or Tow	treet and Numbe n, State)	r or Rural	Route Number,
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To the Hospital or Attanwithin 24 hours after deat To the Funaral Diractor: completely filled in by the	edical	(Check only one)	2 Medicel Exam	ysicien: To the best of iner: On the basis of and manner sta	examination	and/or invi	estigation, in my op	e, date and place, inion, death occur	and due to the c red at the time, c	ause(s) and man late and place, a	ner as sta nd due to	the cause(s)
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CX		16	Boylye	ky, M.	D		P15	306		41181		
[ "		The second	reser of person who o	ompleted cause of de	eath (Item 23	3a) (Type, F	rint) Gran	CALIA	Di + ANI	MOS P	TAL	
* 0		GILBER 31. Date filed (Mon	T BOU	RJEILY 32. Registra	S60	16	CH RA	VEN BL	VP , BA	LTIMOR	E, HI	021239
Sta Registr	0.0	sate mod (MO)	APR 2 1	2005	Carried .	A A	back					

Amend Item 17 pe State of Mary hands Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 9:00 And **Physician** Month Keynods /Medical 4e Fecility Neme (Vinothistitution give street end number)

Ellicott City Kehab Cent 4b. City, Town, or Location of Death 4c. County of Death Examiner ElliCH If Under 24 Hrs. Battumore If Linder 1 Year 5. Social Security Number 7. Age (In yrs. lest birthdey) Birthplace (State or Foreign Country) **Funeral** 213-20-5106 Usual Residence of Decedent 1 ☐ M 2 1 F Vrs Director 10a. State 10c. City, Town or Location 10d. Inside City Limits or 28a-f show traumatic event, the Medical Examiner must be notified at Baltimore 1 ☐ Yes 2 1 No **Funeral Director** 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? Items 23a . Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Quban, Mexican, Puerto Rican, etc.) 14. Race -Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No ff Yes, Give Year or Detes: ò Baltimore, Maryland 21215-0020 1 ☐ Yes 2 1 No þ Specify: 3 Widowed 4 □ Divorced "natural" Be Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiane. Elementery/Secondary (0-12) College (1-4pr 5+) lerk permit. Pages 1 end 2 should be flik Departmant of Health end Mental Hy Important: If Itam 27 Ia marked othwany Injury or other traumetic event 17. Fether's Neme\_(First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Mason Isaiah Wilson Anna 19a. Informant's Name/Ri lationship (Type 19b. Mailing Address (Street and Number or Ruch Route, Number, City or Town, State, Zip Code) Print1 Wilder Daughter Woodstoo 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 ■ Burial 2 □ Cremation Date 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Green Funeral Service 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Vaugna Road Kandellstown MD 21133 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, (up) as cardiac or respiratory arrest shock, or heert failure. List only one cause on each line. Physician Immediate Ceuse (Final disease or condition resulting in death) /Medical CITISTATIC Examiner Due to (or as a consequence of) Examiner The law requires that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical Due to (or as a consequence of) Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 21/No 1 ☐ Yes 2 ☑ No Hospital or Attanding Physician: 25. Wes cese referred to medical examiner? Medical Certification: To Be 26. Plece of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this completely filled in by the funerel di 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation ≯ □ Naturel 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street end Number or Rural Route Number, City or Town, Stete) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the besis of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) ţ 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 20 sueur 30. Neme end eddress of person who completed cause of death (Item 23a) (Type, Print) 1 egistrer's Signature 31. Date filed (Month, Day, Year) State APR 21 2005 Registrar

			For State Registrar	State	of Marylar	nd / Depa	artmen rtificate	t of H	ealth a	and M	lental H		201	05	13	565
		V	1. Decedent's Name (First, Mide	dle, Last)							2. Date of I	Reg. N Death	0.		3. Tim	e of Death
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	Exami		4a. Facility Name (If not institution	on, give street and n	umber)		4b. City,	Town, or	Location of	of Death	MITT		2005 c. County		1:5	0 P "
			3843 Memory I	ane Apt.	В		Ał	oingo	lon					rford	1	
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under Months		If Under		8. Date of E (Month, I	Birth				te or Foreign
	Director		218-01-3781	1 ☐ M 2 🖫 F	84	Yrs.	NOTILIS	Days	Hours	Min.	Jan.				$^{\scriptscriptstyle{try)}}$ z $\mathbf{land}$	
	and		Usual Residence of Decedent  10a. State 10b. Count	v	10c Cit	ty, Town or Lo	antina									
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Maryland	permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 is marked other any injury or other treumatic event, any injury or	To	William Ch. 19a. Informant's Name/Relation		vey				Mary		lizabe		Mill∈			
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	Heal Heal tam		20a. Method of Disposition			lace of Dispos	sition (Name	a ra ent	III RO		Joppa					
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	MARKET IN		shock, or heart failure. List Immediate Cause (Final	only one cause on e	each line.	. Bo not onte	THE HIDGE								Approxim Interval B Onset and	letween
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_	tifical og phy as th															
Вох	death certificate be executed e attending physician and id for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant		come of pregnar								23d Date	of deliver	v	
	0 0	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregn	oirth 2 🗆 Fetal nant at time of de		Ect <i>o</i> pic pred Other <i>(spe</i> d						Mont		Day	Year
0.	by the detached	hys	9 🗆 Unknown	9□ Unkno												
Ś	as ti	by F	Part II. Other significant condition						in Part I.		23e. Did	lobacco u	se contrib	bute to the	cause of	death?
Vital Records,	w require been si		_ chroner a	Columbia	1 puli	m	des	-			1 🗆	Yes 2	□No 3	B 🗌 Proba	bly 🍂	Unknown
ည္ထ	aw ri as be 2 sh	Completed									24a. Was	an	24b. W	ere autops	sy finding	s available
ř	The ate h	E O								_	auto perfe	rmed?	de de	ath?		s available cause of
<u>=</u>	ian: nrtifica	Be	25. Was case referred to medical						6 Place o	of Death	1 ☐ Yes (Check only o	2 No	1 1	Yes 2	LWo	
<u> </u>	> 9771	10	examiner? 1 ☐ Yes 2 No	Hospital:	npatient 2 E	R/Outpatient	3□ DOA	Othor			e Resi		S □Other	(Spanifu)		
_	70 0 0		27. Manner of Death  1 Natural 5 ☐ Pendin	28a. Date of	of Injury th, Day Year)	28b. Time of Injury	280	: Injury a Work?			Bd. Describe					
0	Attanding r death, sector: After by the fune	atic	2 Accident investig	gation	in Buy rour	плату	М		s 2 No	0						
DIVISION	r Att	ertification;	3 ☐ Suicide 6 ☐ Could i 4 ☐ Homicide determ	ined 286. Place	of Injury - At honing, etc. (Specify)	ne, farm, stree	et, factory, o	office		28	Bf. Location (	Street and	d Number	or Rural I	Route Nui	mber,
ב	ital o	Š			-g; ata: (apadiny)						City or To	wn, State,	,			
	To the Hospital or Attanding within 24 hours after death, To tha Funaral Diractor: Aft completely filled in by the fun	Medical	29a. Certifier 1 Certifyin (Check only 2 Medical	g Physician: To the Examiner: On the ba	isis of examinating	rledge, death on and/or inve	occurred at	the time,	date and	place, ar	nd due to the	cause(s)	and manr	ner as stat	ed.	(a)
	ithin 2 o tha omple	Med	one) 29b. Signature and title of certifier		er stated.			icense n								(3)
	× = 3 + 8		100.15											Month, Da		_
0			30. Name and address of person	- 5 (	o of doubt the	00-1-05	1.0	>2	295			ap.	1	15,	200 1	\
D			So. Name and address of person of the solution	And completed cause	() ( ) (Item :	23a) (Type, Pi	O L	)	R.1	A . =	Mo					
	Stat	e		32 R	egistrar's Signatu	ite T	1 n At	/	USI-C 18	31/	1.2					
	Registra	ır	31. Date filed (Month, Day, Year) APR 2 1	2005	egistrar's Signatu	Spe.	Ke !									

State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day 1 4 , 2005 12:25F M Alfred M. Reek /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Saint Joseph Medical Center Towson 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Apr 18, 19 9. Birthplace (State or Foreign Country) New York Funeral Days 81 1 X M 2 □ F Yrs. Director 073-12-6069 Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f show other traumatic event, the Medical Examiner must be notified at MDBaltimore Baltimore 1 ☐ Yes 2X No Directo 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? or items 23e or 8626 Richmond Avenue 21234 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 No If Yes, Give Year or Dates: 143–46 Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) filed within 72 hours after 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify: White 3 ☐ Widowed 4 ☐ Divorced "natural'. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 4 engineer quality control 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be fi and Mental H Fredrick Reek Alvina Liggy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is rr any injury or other traum. 8626 Richmond Avenue Baltimore, MD 21234 Charlotte Mary-Anne Reek/spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ` 4 XDonation 5 ☐ Other (Specify) 21. Signature of Euneral Struce Licensee Wade, State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician DAYS disease or condition resulting in death) PNEUMONIA /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Examiner The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Box 68760. Physician/Medical the ! as IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 4□Pregnant at time of death 5 Other (specify) P.0. the á Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 2 No 3 Probably 4 Unknown 1 Yes Completed 24a. Was an autopsy performed?
1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? certificate has 1 ☐ Yes 2 ☐ No To the Hospital or Attanding Physician: Be 25. Was case referred to medical 26. Place of Death Check onl one examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 XNo 1 Inpatient 2 ER/Outpatient 3 DOA 70 this 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After i Certification: 1 Natural 2 Accident Injury 5 Pending death. 1 ☐ Yes 2 ☐ No investigation Director: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier icai (Check only one) within 2 29b. Signature and title of certifier D 17695 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HELOU M. D. 7601 OSLER DRIVE TOWSON, MARYLAND 21204 31. Date fied Month, Day, Year) State APR 2 1 2005 Registrar

			State of Maryland / Department of Health and Mental Hygiene  Certificate of Death  Reg. No. 2015	C7
	Physic /Medi		1. Decedent's Name (First, Middle, Last)  Charles Schaefer  2. Date of Death  Month   Day Year   2.10	eath M M
	Exami		4a. Pacility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of Death	
	Funeral Director	Г	5. Social Sedurity Number 186–14–4642 12 F 81 Yrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or F. Country)	oreign
	D		100-14-4042	Limits
	he Mary 8a-f sho	ector		
	23e or 2	ai Dir	10e. Street and Number 7909 Quinta Court  10f. Zip Code 20720  10g. Citizen of What Country? USA	
5-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or Items 23e or 28e-1 show any injury or other traumatic event, I'm Medical Exertil at must be routiled at once.	d by Funeral Director	11. Marital Status  1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 3 No or or Dates:  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  14. Race - American Indian, Black, White, etc.  15. Yes 2 No Specify: White	
215-(	within 72 h ene. than "natu	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  16b. Kind of Business/Industry	
d 2121	filed with Hygiene. other than	e Com	12 0 Steam Fitter Heating Co.  17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Sumame)	
Maryland	s should be and Mental is marked o	To Be	Charles Schaefer Ella Bourke	
	is 1 and 2 sl of Health and item 27 is r other traur		19a. Informant's Name/Relationship (Type, Print)  Stephen Schaefer / Son  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  7909 Quinta Court, Bowie MD 20720	
Baltimore,	Pages 1 nent of H int: If ite		20a. Method of Disposition  1	
Balt	permit. Pages Department of Important: If i any injury or once.		21. Signature of Funeral Service Licensee Victor P. Doda, Jr22. Name and Address of Facility  Charles L. Stevens Funeral Home, Inc.	
	Wallet .		23a. Part1. Enter lihe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.    Immediate Cause (Final	en ith
	/Medical Examiner		disease or condition resulting in death)  a. Due to (or as a consequence of):	-5
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying  b. CONDATY OF HETY CISEASE  Due to (or as a conseq ence of):	5
/ Ć	be executed sician and burial-transit	Examiner	cause. Enter Underlying Cause Disease or injury that initiated events resulting in death) Last  C. <u>CEREBYOVAS CULAR ACCIDENT</u> Due to (or as a consequence of):	5
68760,	ficate be ex physician s the burial	icai	d	
.O. Box	The law requires that the death certificate be executed the has been signed by the attending physician and agge 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	r
ds, P	luires that signed to lid be det	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death  1   Yes 2   No 3   Probably 4   Unkr	
Vital Records,	The faw requir sate has been si page 2 should I	Completed	pulmonary disease, peripheral  24a. Was an autopsy findings avair prior to completion of caust	ilable e of
		Be Cor	VASCULAR CISEASE    performed?   death?   1   Yes 2   No       25. Was case referred to medical examiner?   26. Place of Death Check on one)	
of	Phys this ral dii	၉	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)  27. Manner of Death  28a. Date of Injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred	
Division	if or Attending I after death. Diractor: After I in by the funer	ertification;	2 Accident investigation M 1 Yes 2 No	
5	Dir	O	4 ☐ Homicide  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Location (Street and Number or Rural Route Number, City or Town, State)	
	To the Hospital or within 24 hours after To the Funeral Discompletely filled in	edicai	29a. Certifier  (Check only one)  1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	
	with To com	Σ	29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  April 11, 2005	
	0		30. Name and address of persolation completed cadse of death (Item 23a) (Type, Print)  And Appel, MD 295 Spreak - Suite 307 westminster, MD 21157	
*	Sta Registr		30. Name and address of person who completed cadse of death (Item 23a) (Type, Print)  Ann ( Annumery) 295 Sprear Are - 517 307 westminster, Mrs. 21157  31. Date filed (Month, Day, Year) 32. Registrary signature  APR 2 1 2005	

-			1 - For State Registrer	State of Marylar		artment of I rtificate of			giene2 0	05	135	68
	Physic /Medi		1. Decedent's Name <i>(First, Middle, Las</i> Brenda Bea	) trice Spiker				2. Date of De Month APRIL	Day	Year	3. Time of [	
	Exami		4a. Facility Name (If not institution, give $SAINTAGNES$				or Location of Dea	ath	4c. County	<del></del>		
	Funeral Director		5. Social Security Number 6. Se 281-52-1902 10	x 7. Age (In yrs. 52	last birthday) Yrs.	If Under 1 Year Months Days			y, Year) 2,1953	Cou	place (State or ntry) nnati, CH	
	Maryland -I show	tor	10a. State 10b. County MD	10c. Cit	y, Town or Lo Baltin						10d. Inside City	
	h with the 3e or 28a	Funeral Director	10e. Street and Number 6412 Craigmont	Drive		10f. Zip Code 2120	7		10g. Citizen of USA	What Cou	ntry?	
036	72 hours after death with the Maryland 'raturel', or Items 23e or 28a-1 show dical Exam har trust but willled at	by	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1  Yes 2 No If Yes, Give Year or Dates:		Was Decedent of I f Yes, specify Cub 1 ☐ Yes 2 🗷 No	an, Mexican, Pue	Specify Yes or No into Rican, etc.)	14. Rad	ck, White,	can Indian, etc. Thite	
21215-0036	l within jiene.	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)	cation le <i>completed)</i> College (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of wi	orking	16b. Kind of B		dustry	
Maryland	ges 1 and 2 should be filed within it of Health and Mental Hygiene. If item 27 is marked other then or other traumatic event, the Me	To Be C	17. Father's Name (First, Middle, Last) Stanley A. Pra	ther				ame (First, Middle, gia L. Ca		70)		
	1 and 2 sho Health and Iom 27 is mather trauma		19a. Informant's Name/Relationship (T) Christie Kenton/					Ru <i>ral R</i> oute <i>Numbe</i> Cincinnat			Code)	
Baltimore,	permit. Pages 1 ar Department of Hea Important: If item any njury or other once.	1/2	20a. Method of Disposition  1  Burial 2  Cremation 3  4  Donation 5  Other (Specify)	Removal from State	emetery, cren	sition (Name of natory or other pla Cemeter)	ce) 4	Date /11/05	20c. Location -	-		
Balt	permit. Depart Import any nj		21. Signature of Funeral Service Licens			TOUL HAST	<ul> <li>Stevens</li> <li>Fort Ave.</li> </ul>	Funeral Ho Baltimore	MD 21230	)		
	Firysician /Medical Examiner		23a. Part1. Enter the disease, or compi shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequ	BRA1	NIN	JURY.			- 3	Approximate Interval Betwee Onset and De 2 WEEk	eath
68760, <	ficate be executed physician and sthe burial-transit	dical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequ	CAN C	ERI.	T DISI	PCSS .	39/VDK2		LYEAR	
P.O. Box 68	es that the death certificat igned by the attending phy be detached for use as th	by Physician/Medio	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	3c. If yes, outcome of pregna 1 □Live birth 2 □ Fetal 4 □ Pregnant at time of de	death 3 🗌	Ectopic pregnancy Other (specify)	,		23d. Dat Mor	e of delive	ery Day Yea	ar
rds, P	w requires that been signed b should be deta	ed by Ph	Part II. Other significant conditions con	ntributing to death but not resu	ulting in the un	derlying cause giv	en in Part I.		bacco use contr		ne cause of dea ably 4 □Unk	
al Records,	: The law re cate has bee ; page 2 sho	Completed						24a. Was a autops perform	med? d	Vere autoportor to confeath?	psy findings avanpletion of caus	ailable se of
Division of Vital	To the Hospitel or Attending Physicien: The law requires that the death certif within 24 hours after death, within 24 hours after death.  On the Furnatal Director. After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	atlon: To Be	27. Manner of Death  1  Natural 5 Pending 2  Accident investigation	ospital: 1 Inpatient 2 2 28a. Date of Injury (Month, Day Year)	ER/Outpatient 28b. Time of Injury	28c. Injun World	er: 4□ Nursing H	ath (Check only or dome 5 \(\sum \) Reside 28d. Describe he	ence 6 Othe		<i>'</i> )	
Divis	itel or Attend rs after death al Director: led in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, stre	et, factory, office		28f. Location (Si City or Town	treet and Numbe n, State)	er or Rurai	Route Number	r,
	To the Hospitel within 24 hours a To the Funeral I completely filled	Medical	one)	sicien: To the best of my knowner: On the basis of examinat and manner stated.	vledge, death ion and/or inv	estigation, in my of	oinion, death occi	e, and due to the curred at the time, d	ause(s) and mar ate and place, a	nner as stand	ated. the cause(s)	
	To With Con	2	29b. Signature and title of certifier  Morry Possi	the		P 1	7608		9d. Date signed	(Month, L	Day, Year)	
	3		30. Name and address of person who co	O CATON AVE	NUF	BALTIMO	RE MA	HRYLAN	D 212	29	,	
	Sta Registr		31. Date filed (Month, Day, Year)  APR 2	32. Registre's Signat	ure	Goods						

SPIKER, BRENDA.

Physicia	an	1. Decedent's Name		.ast)		SW	/EETWI	NE		2. Date of De	ath 1 Bay	2005	3. Time of Death 10:17 pm
/Medic Examin		4a. Facility Name (/					,	own, or Loc	ation of Death			ounty of Death	10.17
Funeral Director		5. Social Security N 214-64-71	33	Sex 1 □ M 2 ▼F	7. Age (In yrs. <b>51</b>	last birthday) Yrs.	If Under 1 Months		Jnder 24 Hrs. ours Min.	8. Date of Bird (Month, Da 09/08/	th y, Year) <b>1953</b>	9. Birthp Court NC	lace (State or Foreigi try)
yland		Usual Residence of 10a. State	10b. County		10c. Ci	ty, Town or Lo	ocation					1	0d. Inside City Limits
8a-f sh	ctor	MD	Baltimo	re		Pike	esville	9					1 ☐ Yes 2 No
with if	Dire	3929 Avo		ircle			10f. Zip C				10g. Citizer	of What Coun	try?
point. Tages I and a strong before well and well are well as are deaut with the way and Department of Health and Mental Hygiene. Important: If I tam 27 is marked other than "natural", or I tams 23a or 28a-f show any injury or other traumatic avant. If a Medical Examinar must be notified at once.	d by Funeral Director	11. Marital Status 1 ☐ Never Marri 3 ☐ Widowed	ied 2 <b>▼</b> Married 4 □ Divorced	Armed Fo	2 <b>X</b> No /e			nt of Hispar y Cuban, M	nic Origin? (Specify:	pecify Yes or No o Rican, etc.)	- 14.	Race - Americ Black, White, ecify. Black	etc.
"natu	lete		15. Decedent's larger only highest g	rade completed)		16a. Dece (Give	dent's Usual kind of work DO NOT use	Occupation done during	g most of wor	king	16b. Kind	of Business/Inc	lustry
giene. ar than " If e Max	Completed	12th G	rade	2 yrs	I-4or 5+)	Care	Provi				Chi1	d Care	
and Mental Hygiene.	To Be C	17. Father's Name Kennetl		reene						ne (First, Middle, Blanks			
h and 7 is material		19a. Informant's Na Albert E.			and	1				,Pikesvi			/
f Healt f Healt itam 2 other		20a. Method of Disp	position	<del></del>	20b. I	Place of Dispo			CILCIE	Date		ion - City or To	
nage ment o ant: If ury or			☐ Cremation 3 5 ☐ Other (Spec		State Dr	ruid Ri	dge						ID 21208
Departr Departr Importa any inju		21. Signature of Fu	uneral Service Lice		per DVR	8	2. Name and <b>728 Li</b>	Address of .berty	Rd.,	ughn C. Randalls	Green stown,	e Funer MD 211	al Svcs
nysician /Medical Examiner		23a. Part1. Enter the shock, or hea Immediate Cause (disease or condition resulting in death)	ırt failure. List onl (Final	y one cause on e a.	aused the deat ach line. Sepsis (or as a conseq	5	er the mode	of dying, su	ch as cardiac	or respiratory ar	rest,	1	Approximate Interval Between Onset and Death Month
	ilcal Examiner	Sequentially list confrant, leading to imcause. Enter Under that initiated events resulting in death) I	enditions, nmediate orlying injury s Last	С	or as a conseq								
ed by the attending physician and detached for use as the burial-transit	Physiclan/Med	IF FEMALE: 23b. Was decedent in the past 12 1 Yes 2 9 Unknown	months? □No		inth 2 ☐ Feta ant at time of d	death 3□	Ectopic preg				23d	Date of delive Month	y Day Year
n signed t	by	Part II. Other signif	ficant conditions dosis	contributing to de	eath but not res	ulting in the u	nderlying cau	se given in	Part I.				e cause of death?
ocrafficate has been signed by the attentificate has been signed by the attentificator, page 2 should be detached for u	Completed	Accute	Renal	Failure	e	·				24a. Was autop	an 2 sy med? 2 No	4b. Were autop prior to con death? 1 \( \text{Yes}	sy findings available apletion of cause of
this certificate haral director, page	Be	25. Was case reference examiner?		Hospital: , a.r.				0.1	27 - 26 117	th (Check only of			
After this funeral d	atlon: To	1 ☐ Yes 2 🔏  27. Manner of Deatl  X X Natural  2 ☐ Accident		28a. Date of	npatient 2 of Injury th, Day Year)	28b. Time of Injury		Injury at Work?		ome 5 Aesid 28d. Describe h			
i nospital of Attanding 24 hours atter death, I Funaral Diractor: Atte stely filled in by the fune	Certification:	3  Suicide 4  Homicide	6 Could not determine	d 286. Place	of Injury - At he ng, etc. (Specif	ome, farm, str	eet, factory, c	office		28f. Location (S City or Tow		umber or Rural	Route Number,
ara Elle	edical (	29a. Certifier (Check only one)	1X Certifying P	Physician: To the aminar: On the ba and mann	asis of examina	wiedge, death	occurred at vestigation, in	the time, da	ate and place, n, death occur	and due to the or	ause(s) and late and pla	d manner as sta ce, and due to	ited. the cause(s)
ha Hos in 24 hc ha Fun pletely i	Ø.						29c I	icense num	nber		29d. Date si	gned (Month, D	lav Year)
vitin 24 hours after of To the Funeral Director To the Funeral Director Completely filled in by	Me	29b. Signature and	title of certifier	Ma	MD		P	1854	1		April		05
To the House after the Completely filled in	Me	30. Name and addr Carol C	and		e of death (Item		Print) P	1854	1	P	April		

			. For	State of Ma		/ Departme	ent of H	lealth and I				10000
			1 - State Registrar			Certific	ate of	Death		Reg. No.	000	135/1
	Physicia /Medic		1. Decedent's Name (First, Middle, Las Christopher A		ka				2. Date of De Month	Day	Yeer 2005	3. Time of Death
	Examin		4a. Facility Name (If not institution, give	street and number)	. 1	4b. C	ity, Town, o	r Location of Death	2	4c. Co	unty of Deeth	
П			The Johns Hopk	ins Hoo	Pita	1 60	utin	Morel	179		N/A	
	Funeral Director		5. Social Security Number 6. Security N/A	7. Age	(In yrs. las	Yrs.	hs Days	If Under 24 Hrs. Hours Min.	8. Date of Bi	th ay, Ye <i>ar)</i> 		lece (State or Foreign try) Yland
	D .		Usuel Residence of Decedent  10a. State 10b. County		10c City	Town or Location					1	0d. Inside City Limits
	shov	٥	Maryland N/A		•	altimore						1 No 2 No
	r 28a-1	Director	10e. Street and Number				Zip Code			10g. Citizen	of What Cour	
	23a o	al D	2408 Rockwood Av	renue				21209			USA	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23e or 28e-f show important: if Item 27 is marked other than "natural", or Items 23e or 28e-f show any injury or other traumatic event, I'm Medical Examinar must be notified at ance.	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2030 If Yes, Give Year or Dates:			specify Cub	dispanic Origin? (S an, Mexican, Puert Specity:	pecify Yes or No o Rican, etc.)		Race - Americ Black, White, ecity: Wh	
Baltimore, Maryland 21215-0036	n 72 hou "natural solical E	Completed I	15. Decedent's Ec (Specify only highest gra	lucation de completed)		16a. Decedent's U (Give kind of life. DO NO	work done	during most of wor	king	16b. Kind	of Business/In	
12	withi ene. than	mc	Elementary/Secondary (0-12)  N / A	College (1-4or 5- N/A	+)		N/A				N/A	
2	i Hygi other	Be C	17. Father's Name (First, Middle, Last)	14/11			11/44	18. Mother's Nan	ne (First, Middle	, Maiden Sui	пате)	-
a	henta henta rked ric ev	To B	Stephen P.	Smo1ka				Jea	nne M.	Clar	k	
ary	and N is ma		19a. Informant's Name/Relationship (	Type, Print) Parei	nts	19b. Mailing Add	ress (Street	and Number or Ru	ral Route Numb	er, City or To	wn, State, Zip	Code)
<u>∞</u>	l and lealth im 27 her tr	li s	Stephen Smolka &	Jeanne Clai		2408 Roc		l Avenue	Baltim Date		aryland ion - City or To	
5	nt of h		20a. Method of Disposition  1 ☐ Burial ② TXCremation 3 ☐		cen	netery, crematory	or other pla	ce)   ston   4/2				
	artmer artmer ortant injury		* 4 □ Donation 5 □ Other (Specifical Service Licer		Dari	22. Name	e and Addre	ess of Facility			rel, Ma	
Ba	Depa Impo any i		Jum 1	3. Den	SS	) Burge	ee-Hei	nss-Seitz Road, B	Funera	1 Home	Inc.	21211
1	F AL SA		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused	the deeth.	Do not enter the	mode of dyi	ng, such as cardia	or respiratory	arrest,	yrand	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Trisomy								Onset and Death Birth
	/Medical Examiner		resulting in death)	Due to (or as		ence of):						
L	Examiner	<u>_</u>	Sequentially list conditions,	b	a conse us	ince of):						
	ted nsit	nlne	dany, leading to immediate cause. Enter Underlying Cause (Disease or injury	200 (0 (0) 03	a conseque	1100 017.						
Ĺ	sician and burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as	a conseque	ence of):						
)9/	ysicia ysicia	a		d								
89	ntifica ng ph as th	Med	IF FEMALE:									-
D. Box 68760,	The law requires that the death certificate ate has been signed by the attending physpage 2 should be detached for use as the	Physician/Medic	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal c	leath 3⊡Ectop	ic pregnand r (specify) _	ÿ		23d	Date of delive Month	ery Day Year
P.O.	uires that the de signed by the a lid be detached f	/ Ph	Part II. Other significant conditions	contributing to death be	ut not result	ting in the underlyi	ng cause gr	ven in Part I.	23e. Did	tobacco use	contribute to t	he cause of death?
Records,	quires in sign uld be	ed by							1 🗆	Yes 2	he 3 ☐ Prot	pably 4 🗆 Unknown
000	aw requir is been si 2 should l	Completed							24a. Wa	s an 2	4b. Were auto	psy findings available mpletion of cause of
ž	The lav	mo.							perf 1 ☐ Yes	ormed?	death? 1 ☐ Yes	21700
ita	clan: artifica	Be (	25. Was case referred to medical examiner?				77.7	26. Place of De	ath (Check only	one)		
7	hysio this o	은	1 Yes 2 No	Hospital:		· · · · · · · · · · · · · · · · · · ·	] DOA		lome 5 Res			<b>5</b> y)
OU C	ding Physician: The l h. After this certificate ha funeral director, page	ion:	27. Manner of Death  1 Natural 5 Pending 2 Accident investigatio	28a. Date of Inju (Month, Day	Y Year)	28b. Time of Injury M	28c. Inju Wo	ny at ork? ]Yes 2 □No	28d. Describe	now injury o	ccurred	
Division of Vital	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certification completely filled in by the funeral director.	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined			ne, farm, street, fa	-1		28f. Location City or To	(Street and Nown, State)	lumber or Rura	al Route Number,
Ω	To the Hospital c within 24 hours af To the Funeral D completely filled in		29a. Certifier 1 Certifying Pl	nysician: To the best	of my know	ledge, death occu	rred at the t	ime, date and place	e, and due to the	cause(s) an	d manner as s	stated.
	in 24 l in 24 l he Fu pletely	edical	(Check only 2 Medical Examone)	miner: On the basis of and manner sta		on and/or investiga			urred at the time			
	To t To tl	×	29b. Signature and title of certifier	ullend				se number			igned (Month,	
	- 5		- former				r	PES-001		April	17, 20	<b>冷</b>
	1		30. Name and address of person who	4			h 1\	hurcan + D.	Ibana ala	10 217	147	
<b>%</b> c	C+	ate	Janine E. Bullar 31. Date filed (Month, Day, Year)	32. Registr	ar's Signat	PILEGI NE	WIDELD	Vursery Ba	innoise, f	un aio	0/	
	Regist		4	PR 2 1 1000			. 1	Sample Co.				

	1 - For State of Ma	ryland / Department of Health and M Certificate of Death	0000
Physician	1. Decedent's Name (First, Middle, Last)		2. Date of Death Abouth Day Year  2. Date of Death Day Year
/Medical Examiner		SEIDMAN  4b. City, Town, or Location/of Death	Hpr 18 2005 2:02 AM
	Mariner Healthot	Bel Air Bel Air	Harford
Funeral Director	5. Social Security Number 6. Sex 7. Age 215-30-3225	(In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth Office (State or Foreign O1/10/1914) 9. Birthplace (State or Foreign Country) MD
ס	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Location	
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: if time 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic avent, the Medical Examinar must be notified an once.  To Be Completed by Funeral Director		HAVRE DE GRACE	10d. Inside City Limits 1 ☐ Yes 2 🂆 No
with the Mar or 28a-f si be nutified	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
5 ufter death w ritems 23a inner must Funeral I	3606 GREEN SPRING ROAD  11. Marital Status 12. Was Decedent E	21078	U.S.A. acify Yes or No- 14. Race - American Indian,
after do or itan		iver in U.S.  13. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto of the Impart of th	Rican, etc.) Black, White, etc.
hours a tural; of the Every ed by	3 (A) Wildowed 4 □ Divorced Year or Dates:	16a. Decedent's Usual Occupation	
21215-0 ed within 72 ho ygjene. ygjene. is the madical i t, the madical i	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5-	(Give kind of work done during most of worki	ng 16b. Kind of Business/Industry
d 21 lied wi Hygien nt, the		SECRETARY	MEDICAL  (First, Middle, Maiden Sumame)
Baltimore, Maryland 21215-0036  Permit. Pages 1 and 2 should be filed within 72 hours att Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or iny injury or other traumatic avant, ir a Medical Exami Dice.  To Be Completed by F		FINKELSTEIN GOLDIE	FOX
Mary 2 short and hard is ma	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rura	al Route Number, City or Town, State, Zip Code)
re, h	VICKI CHRISTOPHER/DAUGHTER 20a. Method of Disposition	3606 GREEN SPRING ROAD  20b. Place of Disposition (Name of	HAVRE DE GRACE, MD 21078  20c. Location - City or Town, State
imor Pages nent of i	1 💆 Burial 2 □ Cremation 3 □ Removal from State  1 4 □ Donation 5 □ Other (Specify)	TIFERETH ISRAEL 04/20	/2005 ROSEDALE, MD
Balt permit. Departit Importa	21. Signature of Funeral Service Licensee		LEVINSON & BROS., INC.
_ 232.44	23a. Part1. Enter the disease, or complications that caused	the death. Do not enter the mode of dving, such as cardiac o	OAD - PIKESVILLE, MD 21208  Approximate
Priysician	shock, or heart failure. List only one cause on each ling immediate Cause (Final disease or condition	heymonia	Interval Between Onset and Death
/Medical Examiner	resulting in death)	consequence of):	, cocce
Je Je	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Classes of Flury	consequence of):	
D, executed an and rial-transit Examiner	that initiated events resulting in death) Last	200	
		consequence of):	
X 68' certificat nding phy use as the	IF FEMALE:		
	23b. Was decedent pregnant in the past 12 months?	Fetal death 3 Ectopic pregnancy	23d. Date of delivery  Month Day Year
P.O. B. that the death that the death of the detached for Physicia	1 Yes 2 No 9 Unknown 9 Unknown	The original states (specify)	
S, S, be obe obe	Part II. Other significant conditions continuiting to death but	t not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?  1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown
Il Record Il Record The law requir cate has been s page 2 should Completed			24a, Was an 24b. Were autopsy findings available
on of Vital Reding Physician: The lav. After this certificate has funeral director, page 2			autopsy prior to completion of cause of death?  1 ☐ Yes 2 ☐ No
of Vita of Vita Physician: this certifica	25. Was case referred to medical examiner?	26. Place of Death	
on of Valing Physical direction: To	27. Manner of Death 28a. Date of Injury	1 2 EN Outpatient 3 DOA 4 Nursing Hon	ne 5 Residence 6 Other (Specify)  28d. Describe how injury occurred
Division Division I or Attanding after death. Director: After in by the fune ertification	2 Accident investigation	M 1 ☐ Yes 2 ☐ No	
V 2 ← F 5 E E F F	4 Homicide determined building, etc.	y - At home, farm, street, factory, office (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
Division to the Hospital or Attention within 24 hours after death To the Funaral Director: completely filled in by the Medical Certifical	29a. Certifier  (Check only one)  1 Certifying Physician: To the basis of a manner state and manner state.	my knowledge, death occurred at the time, date and place, a examination and/or investigation, in my opinion, death occurred	and due to the cause(s) and manner as stated.  and at the time, date and place, and due to the cause(s)
To the within To the comple	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	NIL IND	134052	April 18, 2005
15	30. Name and address of person who completed cause of dea	North Avinus Bil,	April 18, 2005 Air Manyland 2101x
State Registrar	31. Date filed (Month, Day, Year) APR 2 1 2005	S Signature	

			1 For State	State of M	laryland /		ment of I		d Mental H	4	105	13572
			Registrar  1. Decedent's Name (First, Middle, I	l ast)	-	Certif	icale of	Dealii	2. Date of	Reg. No.		3. Time of Death
	Physici	an	Baby Girl Sa						Month	Day	Year	- 2 .
	/Medi		4a. Facility Name Uf not institution,		)	41	City Town	or Location of De	ath Copper	4c Cou	unty of Death	10:06 AM
	Examir	ier	160 This H	/ //		1 0	2/1	or cocation proc	1: 1	40.000	inty of Death	
		-	5. Social Security Number 6	Sex 7. AC	of (In yrs. last b	pirthday) If	Under 1 Year	If Under 24 H	Irs. 8. Date of I	Birth	9 Rinth	place (State or Foreign
	Funeral Director		none	1□M 2∏F	go ( yroo. o		onths Days			Day, Year) 2005	Cou	ryland
			Usual Residence of Decedent					J 1.	JIPI	, 2005	IIdi	Lyland
	yland		10a. State 10b. County		10c. City, To	wn or Locati	on					10d. Inside City Limits
	Mar fied	호	MD Howar	d		Laure	1					1 ☐ Yes 2X No
	r 28¢	lec	10e. Street and Number		-1	-	10f. Zip Code			10g. Citizen	of What Cou	intry?
	h wit	Funeral Director	9717 Muirkirk H	Road				20708			USA	
	deat	ner	11. Marital Status	12. Was Decedent		13. Was	Decedent of I		(Specify Yes or erto Rican, etc.)	No- 14.	Race - Ameri	
9	after or Ite	Ē	1 XNever Married 2 ☐ Married	Armed Forces					eπo Hican, etc.)		Black, White,	
93	in 72 hours after death with the Maryland "netural", or Items 236 or 286-1 ahow Isdical Examinat must be multired at	1 by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		'0	Yes 2∭ No	Specify:		Spe	ecify: Whit	te
5-0	72 h	Completed	15. Decedent's (Specify only highest of	Education	16	a. Decedent	's Usual Occu	pation during most of v	vorkina	16b. Kind o	of Business/In	ndustry
21	within ene. than "	ď	Elementary/Secondary (0-12)	College (1-4or	5+)	life. DO	NOT use retire	nd)				
2	e filed within al Hygiene. other than vent, the Ma	Ç	none	none		none				non		
<u>n</u>	be fill Ital H Id off	Be	17. Father's Name (First, Middle, La						lame (First, Midd		name)	
yla	2 should be and Mental is marked of aumatic ever	ပ	Andre Placid						armen Sa			
Maryland 21215-0036	2 sh and is m		19a. Informant's Name/Relationship Johns Hopkins		19				Rural Route Nun			o Code)
<b>6</b>	1 and Health em 27	1. 3			ant Bi			e Street	t Baltim			
0	ges 1 and 2 should be filed within to f Health and Mental Hygiene. If item 27 is marked other than or other traumatic event, The Mental Health and the file when the Mental Health and Menta		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3	☐Removal from State	namat	of Dispositio ery, cremato	on (Name of ory or other pla	св)	Date	20c. Location	on - City or To	own, State
Ē	Pa men ant: lury		* 4 □ Donation 5 NOther (Spe	cify) instacte				j				
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		21. Signature of Ronal Straice So	enswade, Dir	ector	Sta	Te and Addr	eson Faciliyoa	rd 655 V	V. Balt	imore	Street
	40 E 4 0		sman/	2// JULE		Bal	timore,	MD 21	201			
			23a. Part 1. Enter the disease, or co shock, or heart failure. List on	mplications that caused by one cause on each I	d the death. Do ine.	not enter th	ne mode of dyi	ng, such as card	iac or respiratory	arrest,		Approximate Interval Between
Z	Priysician		Immediate Cause (Final disease or condition	Ext	Ceme	lie	matu	ritu				Onset and Death  13 Muss
	/Medical Examiner		resulting in death)	Due to (or as	a consequence	e of):		/				
	Lxammer	_	Sequentially list conditions,	b								
	sit s	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence	e of):						
	and -tran	Examiner	that initiated events resulting in death) Last	C. Dug to /or as	a consequence	- of):						
8760,	sate be executed physician and the burial-transit			Due to (or as	a consequence	9 OI).						
87		Physician/Medical		d								
9 ×	eath certific attending p	/Me	IF FEMALE:	220 If you outcome	of programmy				and the second			
Вох	atten atten for us	lan	23b. Was decedent pregnant in the past 12 months?		2 Fetal deat		opic pregnanc	у		23d.	Date of delive Month	ery Day Year
	the de	yslc	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant a 9□Unknown	t time of death	5 🗆 Qtr	her (specify) _					,
P.O.	that the de ed by the detached	Ph	Part II. Other significant conditions	contributing to death t	out not resulting	in the under	tving cause div	ven in Part I	23e Dio	tobacco use c	ontribute to ti	he cause of death?
Vital Records,	w requires that s been signed t should be deta	d by	Severe p	/	\$	mate	car /			Yes 2□No		pably 4 □Unknown
0	requ	Completed	JCVC10 p	comp	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	merce	· WL					
že	has has	Id I								is an 24 copsy formed?	<ul> <li>Were auto</li> <li>prior to cordeath?</li> </ul>	psy findings available mpletion of cause of
a	t: The licate har.								1 ☐ Yes			2 No
<u>===</u>	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			C#		eath (Check only			
	S S S	2	1 Yes 2 No	28a. Date of Inju			DOA		Home 5□Re			y)
n	ding F h. After funera	lo	1 Matural 5 ☐ Pending	(Month, Da	y Year) 200.	Time of Injury	28c. Injui Wor		28d. Describe	e how injury occ	urred	
<u></u>	Attending ir death. ector: After by the fune	icat	2 Accident investigat 3 Suicide 6 Could not	be Ose Bless of Ini	iune Athama 6			Yes 2 ☐ No	OO4 Leastion	(Canada and Ali		10
Division of	I or Attencafter death after death Director: I in by the	Certification:	4 Homicide determine	28e. Place of Inj building, et	ic. (Specify)	arm, street,	ractory, office		City or T	own, State)	moer or Hura	al Route Number,
	pitel ours erel filled		29a. Certifier 1 Certifying	Physician: To the best	of my knowledg	o dooth			on and due to the			<u>`</u>
	Hog 24 h Fun Hely	edical	(Check only 2 Medical Ex	aminer: On the basis o	it examination a	nd/or investi	gation, in my o	pinion, death oc	curred at the time	e cause(s) and e, date and plac	manner as si e, and due to	the cause(s)
	To the Hospitel or Attending Phwitin 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Mec	29b. Signature and title of certifier	and manner of			29c. Licens	se number		29d. Date sig	ned (Month	Day, Year)
	F ≥ F 8		Por	(ma) a M.	lin no		_	5105	9	04	+100	105
			30. Name and address of person wh	o completed cause of	death (Itam 22-)	/Type Brin				U	100/	00187
			June and address of person with	M.L. M. A	LOM	Mesa	4 401-1	Co St.	Baltin	200- 1	Jan.	21001
	Sta	te	31. Date filed (Month, Day, Year)	■2. Registr	rar's Signature	14014	n wor	~ -/	·2001/1/	ione,	will	arece
	Registr	_	APR 2 1 200	J5 Keepe	rar's Signature	book						

			For State Registrar	State of	Marylan		artment rtificate			and M	lental Hy	giene) (	05	13573
	Physici /Medio			lor							2. Date of De Month April	12,200		3. Time of Death 3: 45am м
	Examir	er	4a. Facility Name (If not institution, gi				-		Location o	of Death			nty of Death	Georges
			Prince Georges ( 5. Social Security Number 6.		Age (In yrs.		If Under 1	heve Year	If Under		8. Date of Bir (Month, Da			
	Funeral Director		410-50-1068	1□M 2 <b>X</b> F	78	Yrs.	Months	Days	Hours	Min.	(Month, Da	<sub>ay, Year)</sub> 18 <b>,</b> 1926	Cot	place (State or Foreign intry) Greenwood MS
	P. ,		Usual Residence of Decedent		10n Cit	v. Town or Lo	nation.							10d. Inside City Limits
	anyla show	5	10a. State 10b. County MD Prince	Georges		capito1		hts						1 Yes 2 No
	the M	Director	10e. Street and Number			T. T.	10f. Zip (		_			10g. Citizen o	of What Cou	untry?
	3a or	ī	714 Larchmount	Avenue			2	0743	3			USA		
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, tra Medical Exertiner must be notified at once.	Funeral	11. Marital Status 1 □ Never Married 2 □ Married	12. Was Deced Armed Forc 1  Yes 2	es?	S. 13.	Was Decede	ent of His fy Cubar	spanic Ori n, Mexicar	gin? (Spe n, Puerto	ecify Yes or No Rican, etc.)	)- 14. F	lack, White	_
036	ours aft		3 Widowed 4 Divorced	If Yes, Give Year or Date			1 Yes 2	<b>X</b> No	Specify:			Spe	cify: L	Black
2	72 hc	etec	15. Decedent's E (Specify only highest gi	ducation ade completed)		(Give	dent's Usual kind of work DO NOT use	done d	lurina mos	t of worki	ng	16b. Kind of		ndustry
7	within ene. than	Completed by	Elementary/Secondary (0-12)	College (1-4	for 5+)		vurse	a reureu,	,			Hosp	oital	
פ	other other	Be C	17. Father's Name (First, Middle, Las	')								, Maiden Sum	ame)	
ylai	Ments Ments arked	To E	John Wallace V								Hodges			
Maryland 21215-0036	od 2 shoulth and 27 is m		19a. Informant's Name/Relationship  James Welch/Brod					•				er, City or Town		ip Code)
altimore,	of Hee item item		20a. Method of Disposition	<b>4</b> 5		lace of Dispo emetery, cre	sition (Name	e of her place	e) 0		ate	20c. Locatio	•	
Ē	Page ment ant: If ury or		1 ☐ Burial 2 ☐ Cremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Spec	fy)	To	d Ceme	etery		U	4/20,	/2005	Young	stown	OH
Ball	permit. Depart import any inj		21. Signature of Funeral Service Lice	nsee		22	2. Name and	es L	Stev	ens F	uneral H	ome Inc. MD 2123	0	
760,	Physician /Medical Examiner  physician and physician and physician and physician and physician are physician at the physician and physician are physician at the physician at	ical Examiner	23a. Part1. Enter the disease of conshock, or heart failure. List only immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or	on line.	eumonia uence of): uence of):								Interval Between Onset and Death
.O. Box 68	death certific e attending p id for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		th 2 ☐ Feta ntattime of d	Ideath 3	⊒Ectopic pre ⊒ Other (spe						Date of delin	rery Day Year
Ω.	res that igned b	by Pr	Part II. Other significant conditions	contributing to dea	th but not res	utting in the u	nderlying ca	use give	n in Part I			5.7		the cause of death?
ord	w require been si should i	ted									1			bably 4 Unknown
I Records,	The lar	Completed									24a. Was auto perfo		prior to condeath?	opsy findings available ompletion of cause of 2 \sum No
/ita	ician: sertific ector,	Be	25. Was case referred to medical examiner?	Hospital:				Othe	10		(Check only			
o	Physician: r this certifica ral director, I	. To	1 Yes 2 No 27. Manger of Death	1 🗆 Int	natient 2 5	ER/Outpaties 28b. Time o			4 140			dence 6 00		ify)
on	ding Afte fune	ation;	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of (Month)	, Day Year)	Injury	М	Bc. Injury Work 1 🗀 Y	? /es 2 □	No				
Division of Vital	5 # F 5	Certifica	3 ☐ Suicide 6 ☐ Could not determine	4   289. Place 0	of Injury - At hig, etc. (Specif	ome, farm, st	reet, factory,	office			28f. Location ( City or To		mber or Rui	al Route Number,
	To the Hospital within 24 hours e To the Funeral completely filled	edical Ce		hysicien: To the b miner: On the bas and manne	is of examina									
	ro the within ro the somple	Me	29b. Signature and title of certifier						number			29d. Date sig		
			> Shoul 1/2	I	HO		D	5	08	62	-	APR	14,1	2,2005
	}		30. Name and address of person who Sherif Hassan	completed cause				1t.N	4D 20	770				
	Sta		31. Date filed (Month, Day, Year)		gistrar' Signa									
	Regist	ar	APR	2 1 2003	A Rolling	الماكر الماكا	P	rio de la composición dela composición de la com						

30x 68760, Sax 68760,

			Plea  1 - State Registrar	se Type or Prin State of Ma		Depa		t of H	lealth	and M	-		9005	13574
	Physici /Medic		1. Decedent's Nam <i>e (First, Middl</i> <b>Cynthia</b>	. ,	3						2. Date of D Month	eath D	ay Yea	
	Examir		4a. Facility Name (If not institution Stella Maris	At Mercy			В	alti	more				c. County of D	
	Funeral Director		5. Social Security Number 098-46-7103 Usual Residence of Decedent	6. Sex 7. Age 1 ☐ M 2 🕦 F	51	Yrs.	If Under Months	Days	Hours	Min.	8. Date of B (Month, D August	irth 23, Yea 23,19	9. 1 953 Fe	Birthplace (State or Foreign Country) DICT KNOX, KY
	Maryland B-f show iffed at	tor	10a. State 10b. County	altimore	10c. City, To	wn or Lo								10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	th with the 23a or 28 ust be not	al Director	10e. Street and Number 6929 Reistert	own Road			10f. Zip	Code 1215				10g. C	itizen of What USA	Country?
200	be filed within 72 hours after death with the Maryland ital Hygiene. d other than "natural", or itams 23a or 28a-f show avent, the Medical Exatt he invited indifficulat	by Funeral	11. Marital Status  1 Never Married 2 Marr 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? ied 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:			Was Deced If Yes, spec 1 ☐ Yes		ispanic O in, Mexica Specify		cify Yes or N Rican, etc.)	lo-	14. Race - A Black, W Specify: B	
1213-0030	within 72 ho ene. than "natur he wedical	Completed	15. Deceden (Specify only higher Elementary/Secondary (0-12)	t's Education st grade completed) College (1-4or 5		(Give	dent's Usua kind of wo DO NOT us	rk done i se retired	durina mo	st of worki	ng	16b.	Kind of Busine	ss/Industry
ומוות ע	d tal	To Be Co	17. Father's Name (First, Middle, Alexander 1				ر بادر				(First, Middle tta Bu			
Maly	d 2 in h ar		19a. Informant's Name/Relations Lovie D. Bo				ng Address			Dan		ber, City	or Town, State	
pallillore,	permit. Pages 1 and Department of Healt Important: If Itam 2 any injury or other once.		20a. Method of Disposition  1 Burial 2 Cremation  4 Donation 5 Other (S	pecify)	Spring	Hill Hill	natory or o	ther plac ery		4/21	/ 05		Location - City Parleston	
ב מ	Departition Depart		21. Signature of Funeral Service	<b>5</b> .	Zizos		Charl 1501	es L Fast	Stev Fort	ens Fu Ave Ba	neral H Itimore	iome I MD 2	nc. 21230	
	Physician /Medical Examiner		23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	a	e. Ha	daki	er the mod	_	g, such as		r respiratory	arrest,		Approximate Interval Between Onset and Death
,00,00	eath certificate be executed attending physician and for use as the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a c. Due to (or as a d.		,								
	0 0	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 pronths? 1  Yes  No 9  Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at 9 □ Unknown	Fetal dea		Ectopic pro Other (sp.						23d. Date of o	delivery Day Year
(58.00	w requires that the desbeen signed by the a should be detached for	by	Part II. Other significant condition	ins contributing to death bu	t not resulting	in the ur	nderlying ca	ause give	n in Part	l.		Did tobacco use contribute to		to the cause of death?
	The law ate has b page 2 si	Completed									24a. Was auto perf		prior t death	autopsy findings available o completion of cause of ? es 2 \sum No
2010	Phys this ral di	Certification: To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death  1 Acident investig  3 Suicide 6 Could	Year) 28b	28b. Time of Injury M 28c. Injury at 28d. Described Work?					ne 5□ Res 8d. Describe	cont one ☐ Residence 6 ⊟other (Specify) ☐ Scribe how injury occurred			
	To the Hospital or Attanding within 24 hours after death. To the Funeral Director: After completely filled in by the funeral Director.	70	4 Homicide determ  29a. Certifier 1 Certifyin (Check only 2 Medical	f my knowled	At home, farm, street, factory, office  28f. Location City or  by knowledge, death occurred at the time, date and place, and due to the amination and/or investigation, in my opinion, death occurred at the time.						wn, Stat	e)	as stated	
	To the Hospital within 24 hours a To the Funeral I completely filled	Medica	29b. Signature and title of certifie	and manner stat	ed.	and or INV			number	-/	u at the time,			nth, Day, Year)
	Sta	F	30 Name and address of person  31. Date filed (Month, Day, Mass)	selvera 301	ath (Item 23a	PC.	Print)	alle)	Bal	Lina	OVC 0	nd.	213	02

State of Maryland / Department of Health and Mental Hygiene 3575 Certificate of Death Reg. No. 3. Time of Death 2. Date of Deeth 1. Decedent's Name (First, Middle, Last) Year Apri 7 Am **Physician** 2005 Turner Thelma Browning /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street end number) Examiner Sykesville Carroll 2041 Stillwater Road If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yeer) March 26, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Yeer) Months 1 ☐ M 2 🕱 F Yrs. 233-44-4703 77 1928 West Virginia Director Usual Residence of Decedent 10d. Inside City Limits 10a State 10c. City, Town or Location r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yes 2X No Sykesville Director Maryland Carroll 10e. Street end Number 10g. Citizen of What Country? 21784 United States 2041 Stillwater Road Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S Armed Forces? 11 Marital Status Black, White, etc. filed within 72 hours efter 1 ☐ Yes 2 ☑No If Yes, Give Yeer or Dates: 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 TNo Specify: Specify: White <u>≽</u> 3 ☐ Widowed 4 ☑ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Chessie System Secretary 12th permit. Pages 1 and 2 should be filed v Depertment of Health and Mentel Hygie Important: If Item 27 is marked other I 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Jare11 Golden Browning Berta 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2041 Stillwater Road Sykesville, MD 21784 Son David Moore 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State April 20, 2005 Winfield, MD South Carroll Crematory ation 5 Other (Specify) 4 🗆 D 22. Name and Address of Facility
Burrier-Queen Funeral Home & Crematory, PA 21. Sig of Funeral Service Licens 1212 W. Old Liberty Road Winfield, MD 21784 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** CARDIAC ARRHYTHMIA Immediate Cause (Final disease or condition resulting in death) /Medical **Examiner** Examiner MYO CARDIAI, attending physician end for use as the burial-trensit certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physiclan/Medical Due to (or as a consequence of): The law requires that the death 23b. Did tobacco use contribute to the ceuse of death? P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. the a signed by the 1 Tes 2 1 No 3 Probably 4 Unknown Division of Vital Records, þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en autopsy performed? Completed need hes TUYES 2ULHO 1 ☐ Yes 2 ☐ No or Attending Physician: Be 25. Was case referred to medical 26. Place of Death Check only one) Hospital: Other: 4 Nursing Home 5 PAesidence 6 Other (Specify) 1 ☐ Yes 2 ☐ No P 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? Certification: efter death. Director: After t Natural 5 Pending investigation 1 Tes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 I Homicide To the Hospital or within 24 hours eft To the Funerel Dicompletely filled in 1 Dertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29d. Date signed (Month, Dey, Year) 29c. License number Var 022220 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) Rd Sykesville M 32 Registrar's Signature lis 31. Date filed (Month, Day, Year) State

Registrar DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death HOMPSO Yea ERRI APRIL 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death PL AND ALLSTOWN BALTIMORE SUNALYTE NONTHWEST AT If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex Days Hours 1 □ M 2 💢 F 213-86-Usual Residence 10d. Inside City Limits 10b. County 1 ☐ Yes 2 No Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S Armed Forces? 1 □ Yes 2 No If Yes, Give 11, Marital Status Never Married 2 ☐ Married 1□Yes 2XNo Black 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) ne (First, Middle, Maiden Sumame) rst, Middle, Last hompson other Method of Disposition 3 Removal from State 2 Cremation 5 Other (Specify) Istown, MD 23a. Part. Eter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final EAST disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): that initiated events resulting in death) Last

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

10a State

Director

Funeral

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Completed

Be

**Funeral** 

Director

show

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"naturel", or Items 23a

permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Importent: if item 27 is marked other than "naturel", or Iter paying or other treumatic event, the Medical Eventi en ance.

Baltimore, Maryland 21215-0036

other treumatic event, the Medical Examiner must be notified at

death with the Maryland

Examiner use as the burial-transit Physician/Medical þ

Completed

Be

The law requires that the death certificate be executed

To the Hospital or Attending Physicien:

hours after death.

within 24 hours after death To the Funerel Director:

this

Division of Vital Records, P.O. Box 68760,

IF FEMALE 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No
9 Unknown

25. Was case referred to medical examiner?

2 **X**0No

5 Pending

investigation

6 Could not be determined

1 Yes

27. Manner of Death

1 Ratural

Accident

3 Suicide

29a. Certifier

4 - Homicide

23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 Inpatient

28a. Date of Injury (Month, Day Year)

4 Pregnant at time of death

Due to (or as a consequence of):

3 Ectopic pregnancy 5 Other (specify)

3 DOA

23d. Date of delivery Day Month

Year

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ known

24a. Was an

24b. Were autopsy findings available prior to completion of cause of death?

autopsy 2 **D**Vo Yes

1 Yes ZONO

26. Place of Death (Check only one)

Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

Location (Street and Number or Rural Route Number, City or Town, State)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifie

29c. License number

2 No

Other:

1 TYes

28c. Injury at Work?

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year) APRIL

30. Name and address of person who completed cause of death (Item 23a) (Type 10

2 ER/Outpatient

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

State Registrar

31. Date filed (Month)

			State of Maryland / Department of Health and M  1 - State Registrar  Certificate of Death  1. Decedent's Name (First, Middle, Last)		leg. No. UU D	3. Time of Death
	Physic		Rosalie Constance Wyrobek	Amonth	20 200.	
	/Medi Examii		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death	.)	4c. County of Dea	ath
			North Arunner Hospital Glen Burnie		Anne Ar	
	Funeral Director		5. Social Security Number 6. Sex 1 Months 1 Months 2 MF 7. Age (In yrs. last birthday) 1 If Under 1 Year 1 If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth Month, Day 02/23	71930 9. Bi	rthplace (State or Foreign ountry)
	and w		Usual Residence of Decedent  10a. Slate 10b. County 10c. City, Town or Location			10d. Inside City Limits
	h the Marylan ir 28e-f show	tor	MD Anne Arundel Pasadena			1 ☐ Yes 2 🛣 No
0	deeth with the Maryland ms 23e or 28e-f show r must be notified at	Director	10e. Street and Number 10f. Zip Code	1	10g. Citizen of What C	ountry?
· <del>A</del>	s 23e	ral	8429 Garden Road 21122	- 7 10 - 11	U.S.A.	
A.	ĕ <u>₽</u> ≅	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Never Married 2 □ Married  1 □ Yes 2 ♥ No  1 □ Never Married 2 □ Married  1 □ Yes 2 ♥ No	Rican, etc.)	14. Race - Am Black, Wh	
ROSALIE 0036	hours after tural', or Ite	þ	3 ☑ Widowed 4 ☐ Divorced If Yes, Give 1 ☐ Yes 2 ☑ No Specify:		Specify: W	hite
r.c	72 hours "netural", rdical Ex	Completed	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of work)  [file DO NOT use retired)	ing	16b. Kind of Business	s/Industry
× 5	within 72 ho liene. r than "netu	Jumo	Elementary/Secondary (0-12) College (1-4or 5+)  7  College (1-4or 5+)  Homemaker		Own Hom	9
SE od 2	should be filed within of Mental Hygiene. marked other than matic event, Ite M.	Be Co	17. Father's Name (First, Middle, Last)  18. Mother's Name	(First, Middle,		
305	ould be Mental narked o	To B	Frank Buchacz Anna O	lszews	ki	
MYROBEK, ROS Maryland 21215-0036	2 sho		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rura			
			Diane Schultz / Daughter 8429 Garden Road,  20a. Method of Disposition (Name of		na, MD 2	
4	Pages nent of int: If it		1 Burial 2 Cremation 3 Removal from State  1 Donation 5 Other (Specify)  1 Bayview Crematory 04/	23/05	Baltimor	a. MD
<u>+</u>	permit. Pages Department of Important: If i any injury or once.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility G.			
<u> </u>	1 & 3 E & 3		169 Riviera Dri			MD 21122 Approximate
	Proposition   Proposition	Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events			Interval Between Onset and Death
8760.	cate be exectly solution and the burial-t	cal	resulting in death) Last  Due to (or as a consequence of):  d. ==			
O. Box 68	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medi	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown  23c. If yes, outcome of pregnancy  1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown  23c. If yes, outcome of pregnancy  1 Live birth 2 Fetal death 5 Other (specify)		23d. Date of de Month	olivery Day Year
rds.	w requires that been signed b	b	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		bacco use contribute t es 2 ☐ No 3 ☐ P	o the cause of death?
Division of Vital Records. P.O.	The law re ate has bee page 2 sho	Completed		24a. Was a autops perform	sy prior to med? death?	utopsy findings available completion of cause of s 2 No
Vita	ysician: Th is certificate director, pag	Be	25. Was case referred to medical examiner?  Hospital: Other: Other: Other:			
of	Phys r this oral dir	T. To	1 Yes 25 No 1 Compalient 2 ER/Outpatient 3 DOA 4 Nursing Hor		ence 6 Other (Spector ow injury occurred	acity)
ion	nding Fath. r: After e funer	atlor	1 Natural 5 Pending (Month, Day Year) Injury Work? 2 Accident investigation M 1 Yes 2 No			
Divis	after death after death Director: d in by the	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Si City or Town	treet and Number or F n, State)	lural Route Number,
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director. After this certifica completely filled in by the funeral director,	ledical C	29a. Certifier (Check only one)			
	To the within To the comp	M	29b. Signature and title of certifier  Hen Fig. W  DO 27415		9d. Date signed (Mon 4/4/200	
	6		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  - Henry Franc's Mo, North Arundel +	tospt	7 ]	
	Sta Regist	ate rar	31. Date filed (Month Pay Year)  APR 2 1 2005  32. Phistrar's Signature			

			1 - For State Registrar	ate of Maryland / Dep. <i>Ce</i>	artment of Health rtificate of Deatl	h	giene 005	13578
	Physici		1. Decedent's Name (First, Middle, Last)  ROBENT Wal	Ker		2. Date of De Month	ath Day Year (6 200)	3. Time of Death
	/Medic Examir		4a. Facility Name (If not institution, give street future case Change	and number) word	4b. City, Town, or Location	of Death	4c County of Death	
	Funeral Director		5. Social Security Number 6. Sex 15/M :	7. Age (In yrs, last birthday)	If Under 1 Year If Under Months Days Hours	or 24 Hrs. 8. Date of Bir Min. (Month, Da	th 9. Birth Con	nplace (State or Foreign untry)
	aryland show	<u>.</u>	Usual Residence of Decedent  10a. State  10b. County	10c. City, Town or L	1.1	>./		10d. Inside City Limits
	ith the Mi or 28a-f	Director	10e. Street and Number	e	10f. Zip Code	UN	10g. Citizen of What Cou	
	r death w	Funeral	/ A	med Forces?/	Was Decedent of Hispanic C If Yes, specify Cyban, Mexic	Origin? (Specify Yes or No an, Puerto Rican, etc.)	14. Race - Amer Black, White	
5-0036	72 hours after death with the Maryland natural', or Items 23a or 28a-f ehow Jisal Esairia ar must be trofffled at	٥	3 ☐ Widowed 4 ☐ Divorced Y	☐ Yes 2 (12/No Yes, Give ear or Dates:	1 ☐ Yes 2 ☐ No Specif	y:	Specify: B	ACK
2	within 72 Pene. than "nat	Completed	15. Decedent's Education (Specify only highest grade com	pleted) (Give	Ident's Usual Occupation of kind of work done during mo DO NOT use retired)	ost of working	16b. Kind of Business/I	Notos
and 21	I be filed with ntal Hygiene. ed other ther evant, the M	Be	17. Father's Name (First, Middle, Last)	ΙΟ π   1	18. Mot	her's Name (First, Middle)	COLUMN TO THE TAXABLE PROPERTY.	(unknow)
Maryland	12 should be f h and Mental H 7 Is marked of raumatic eva	인	19a. Informant's Name/Relationship (Type, P	rint) 19b. Maili	ing Address (Street and Num	INNIC ber or Rural Haute Number	er, City or Town, State, Z	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural; or Items 23a or 28a-1 ehow any injury or other traumatic evant, the Medical Examble in the Indilled at once.		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ Remov	at from State	osition (Name of matory or other place)	Date	20c. Location - City or 1	Toron services
Baltimore,	permit. Pag Department Important: I any injury o		'4 □Donation 5 □Other (Specify)  21. Signature of Funeral Service Licensee		2. Name and Address of Fac		Baltimor Greene Pune	ral Service
	40 = 60		23a. Part1. Enter the disease, or complication shock, or heard filure. List only one can	ns that caused the death. Do not enuse on each line.	ter the mode of dying, such a		toun, MD	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequence of):	aeridat			Grider and Double
V	Examiner	ner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to rr as a consequence of):				
,00	be executed ician and burial-transit	Examiner	Cause (Disease or injury that initiated events c c c.	Due to (or as a consequence of):	George			
68760	rtificate be e) ng physician s as the buria	Medical	d					
.O. Box	The law requires that the death certificate be executed tte has been signed by the attending physician and age 2 should be detached for use as the burial-transit	Physician/Me	23b. Was decedent pregnant in the past 12 months?		□Ectopic pregnancy □ Other (specify)		23d. Date of delin	very Day Year
ds, P.	uires that signed b		Part II. Other significant conditions contributions of the substitution of the substit	ing to death but not resulting in the wardeles trelling	underlying cause given in Part	¥	obacco use contribute to Yes 2 □ No 3 □ Pro	the cause of death?
Records,	ne law requir s has been si ige 2 should	Completed by					prior to compad? death?	opsy findings available ompletion of cause of
of Vital		Be	25. Was case referred to medical examiner?	al:	Other I.e.	1 ☐ Yes		
on of	ling Phys	ion: To	27. Manner of Death  1 Natural 5 Pending	a. Date of Injury  (Month, Day Year)  a. Date of Injury  Injury	nt 3 DOA 4		how injury occurred	ity)
Division	or Attano after death Diractor: in by the	Certification:	2 Thousand 6 Thousand not be	e. Place of Injury - At home, farm, st building, etc. (Specify)			Street and Number or Rui wn, State)	ral Route Number,
	To the Hospital or Attanding Physician: within 24 hours after death. To the Funaral Diractor: After this certifical completely filled in by the funeral director,	edical C	(Check only 2 Medicel Examiner: (	: To the best of my knowledge, deal on the basis of examination and/or in and manner stated.	th occurred at the time, date a nvestigation, in my opinion, de	and place, and due to the eath occurred at the time,	cause(s) and manner as date and place, and due	stated. to the cause(s)
	To the within To the compli	Me	29b. Signature and title of certifier		29c. License number		29d. Date signed (Month	
	5		30. Name and address of person who comple	ted cause of death (Item 23a) (Type	Print) 5, Radall	stown, Man	y(an)	
:	Sta Registi		31. Date filed (Month Reg.) 1 2005		beets			

			riease	Chata of Many				•			•
			1_ For State	State of Mary	•	icate of Dea		aniai m		2005	13570
			Registrar  1. Decedent's Name (First, Middle, La	st)	Oertii	icate of bea		2. Date of D	Rag. N	0.000	3. Time of Death
	Physici		Λ Ι		ERDAL	=		A DR	7 15	Year	55:05 PM
	/Medic Examin		4a. Facility Name (If not institution, giv			. City, Town, or Locati	on of Death		4	c. County of De	ath
	_xami	Ŭ. 	GENESIS		4	EVERNA	PARK		A	NNE A	RUNDEL
	Funeral		5. Social Security Number 6. S	ex 7. Age (In		Under 1 Year If Unonths Days Hou	der 24 Hrs. rs Min.	8. Date of B (Month, D	irth ay, Year	9. B	irthplace (State or Foreign
	Director		Usual Residence of Decedent		81 Hs.			11-2	8 -	23 No	BHASKA
	yland yland		10a. State 10b. County	100	c. City, Town or Locati	-				<del></del>	10d. Inside City Limits
	Man B-f eh	tor	MD ANNEA	eundel	GLEN E	BURNIE					1 Yes 2 No
	or 28	Director	10e. Street and Number	1.		Of. Zip Code	5		10g. C	itizen of What (	Country?
	ath w	rail	400-D WOODL	ake ct		2106	اد	" N		0.5	, A ·
	lterne Item	Funerai	11. Marital Status  1 □ Never Married 2 ☑ Married	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☐ No	in U.S. 13. Was	Decedent of Hispanic is, specify Cuban, Mex	ican, Puerto R	ity Yes of N lican, etc.)	10-	14. Race - Arr Black, Wh	
336	al', or	ρ	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1 🗆	Yes 2 No Spec	cify:			Specify:	)hITE
21215-0036	within 72 hours after death with the Maryland sne. han "ratural", or Iteme 23a or 28a-f ehow ha Medical Examinar must be notified at	Completed	15. Decedent's E (Specify only highest gra	ducation	16a. Decedent	's Usual Occupation	nost of workin	<u></u>	16b.	Kind of Busines	s/Industry
21	ithin ne.	npie	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO	NOT use retired)		9	1		10-11-2=
	filed w Hygier sther th		17. Father's Name (First, Middle, Last		OFFIC	EMANA	other's Name	/First Middl			Y College
anc	d be fantal h	) Be	FREDERICV	MATHER	NS	0	LIVE	Alv	A	A	
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylar if Health and Mental hygiene the statusti, or iteme 23s or 28s-1 show item 27 is marked other than "natural", or iteme 20s or 28s-1 show other traumatic event, the Medical Exprines must be notified at	2	19a. Informant's Name/Relationship (			ddress (Street and Nu.		Route Num	ber, City	or Town, State,	Zip Code)
	1 and 2 Health al em 27 is		ROPERT WESTERD	ALE HUSBAN	D 400-04	DODLAKE C	T. Cla	ENBL	RNIE	= MD &	2061
ore,	es 1 a of He fitem r othe		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐	2	Ob. Place of Disposition Comptery, cremator	n (Name of ory or other place)	Da	ite	30c. I	Location - City of	r Town, State
Ë	Pages ment of ant: If it ury or o		'4 Donation 5 Other (Special		SANIEW CRI	EMATORY	4-20	-05	BAL	TOPPE	E, MD.
Baltimore,	permit. Pages 1 and Department of Health Important: If item 27 any injury or othar ti once.		21. Signature of Funaral Source Lice	1see	22. No	ame and Address of Fa Daugherty Family		ne And Cre	mation	Center, P.A.	
	40 = 4 0		23a Part 1 Enter the disease or com	dications that ansee the	death. Do not enter th		ain Road -			21122	Approximate
			23a Part 1. Enter the disease, or comshock, or heart failure. List only Immediate Cause (Final	one cause on each line.		-1		1:			Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. HED	elmer	-2 OE	mer	7710			years
	Examiner										
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a co	nsequence of):						
	ecuter and transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c						<del></del> .	
760,	te be executed ysician and ne burial-transit		Tossiting in doutiny East	Due to (or as a co	nsequence or):						
687	The law requires that the death certificate be executed te has been signed by the attending physician and oage 2 should be detached for use as the burial-transit	dicai	•	d							
Box (	leath certificate attending phys I for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregpant	23c. If yes, outcome of pr						23d. Date of d	elivery
B	death e atter	ciar	in the past 12 months?	1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time		opic pregnancy her (s <i>pecify</i> )				Month	Day Year
P.O.	tt the by the tache	hys	9 Unknown	9□ Unknown							
S, F	res that the der signed by the a be detached for	by F	Part II. Other significant conditions	contributing to death but no	t resulting in the under	fying cause given in Pa	art I.			-	to the cause of death?
ord	w require been signatured should b							1	Yes 2	2 <b>□</b>    <b>/</b> ¶o 3□  F	Probably 4 □Unknown
lec	has by	Completed						24a. Wa aut	s an opsy formed3/	24b. Were a prior to death?	autopsy findings available completion of cause of
a F								1 ☐ Yes	212N		s 2 No
of Vital Records,		Be c	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient	2 ER/Outpatient	Other	lace of Death			6 ☐Other (Sp	aniful
of	Phys er this eral di	n: To	27. Manner of Death	28a. Date of Injury	28b. Time of	28c. Injury at Work?				ury occurred	ocity)
ion	ath. r: Afte e fun	atio	1 Patural 5 Pending 2 Accident investigation	(Month, Day Ye		M 1 Yes 2	2□No				
Division	r Atte er de recto by th	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	e 28e. Place of Injury - building, etc. (S	At home, farm, street, pecify)	factory, office	2	Bf. Location City or To			Rural Route Number,
	ital or irs aft ral Di										
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical		nysician: To the best of my niner: On the basis of exa and manner stated.							
	o the ithin 2 o the omple	Mec	29b. Signature and title of certifier	and mariner stated.		29c. License numb	er		29d. D	ate signed (Moi	nth, Day, Year)
	⊢ ≯ ⊢ ŏ		MI		MI	1)50	2725	5	4	-19-	2005
•	Ĺ		30. Name and address of person who	completed cause of death	(Item 23a) (Type, Prin	it)	4 4 1 1	·	·/		
			Jenni Ferkied	iouer 860	1 Vetera	rs Hwy	Nill	MSV	lle	MI	2005
			.31. Date filod (Month, Day, Year)	32. Registrar's	Signature						_

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 1 ten#19a, perFH, G842, 4-21-05 TF State of Maryland / Department of Health and Mental Hygiene

1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 10:31 PN 2005 MARY ABERDEEN WATSON /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore GoodSa marchin If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 M XXF Yrs. 09/15/1946 MARYLAND 58 Director 215-46-7134 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County or 28a-f show the Medical Examiner must be notified at XXYes 2 □ No BALTIMORE CITY Director MD N/A10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 238 21234 USA 2375 PERRING MANOR ROAD Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes YVNo
If Yes, Give
Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 'natural', or Items Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: BLACK ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) BURLINGTON COAT Elementary/Secondary (0-12) College (1-4or 5+) ACCOUNTING 12TH 12 should be filed w and Menta! Hygier Is markad other ti FACTORY 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be MARY MORGAN ပ SAUNDERS THOMAS 19a. Informant's Name/Relationship (Type, Print)
Bustion 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 and 2 and 2 and 2 and 2 and 2 and 1 and 27 ls and 1 and 1 and 27 ls and 1 and 1 and 27 ls GRANDTER 877 N. AVONDALE RD., BALTIMORE, MD 21222 MONIQUEBUSTION 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 4/22/05 BALTIMORE, MD TRINITY CEM. 22. Name and Address of Facility HOWELL FUNERAL HOME 21207 21. Signature of Uneral Service Licensee 23a. Part Enter the disease, or complications that caused the deshook, or heart failure. List only one cause on each line. 4600 LIBERTY HEIGHTS AVE, BALTIMORE, Approximate Interval Between Onset and Death n. Do not enter the mode of dying, such as cardiac or respiratory arrest, Probable Myscordick UNKADEUM **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine burial-transit certificate be executed that initiated events end resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 Physician/Medical the as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23h Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 1 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ HIKNOWN Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 2 100 Division of Vital or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury 1 Natural 5 Pending 2 No death investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours To the Funerel 29a. Certifier 1 🗹 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 00042658 April, 16, 2005 Atom m.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5601 Loct Raven Bird. MITZCLaw TepHen 31. Date filed (Month, Day, APR egistrar's Signature State Registrar

1916

# PATIENT KNOWN AS ROBERT WEEAST Baltimore, Maryland 21215-0036

sici		For State Registrar  1. Decedent's Name (First, Middle, Las	21	Cei	rtificate of E	Jean	2. Date	Reg. No.*	000	3, Time of Deat
	200	1. Decedent's Name (First, Middle, Las Robert Weeast	51)				APR	Day	2005	
edic	al	4a. Facility Name (If not institution, give	a street and number)		4b. City, Town, or	Location of			County of Deat	
ımin	er		TLOF BAL	TIMORE		More	_	7.		
ral		5 Social Security Number 6 Se	ex 7. Age (In	yrs. last birthday)	If Under 1 Year Months Days	If Under 2		of Birth h, Day, Year) 23, 19	9. Bírt	thplace (State or For
tor		147-05-5150	X M 2□F 5	9 Yrs.	Monais Days	110013	June	723, 19	945	
		Usual Residence of Decedent  10a, State 10b, County	100	c. City, Town or Lo	ncation					10d. Inside City Lir
100	5	MD MD		•	altimore					1 <b>∑</b> Yes 2 □
9	ect	10e. Street and Number			10f. Zip Code			10g. Citiz	en of What Co	untry?
	Funeral Director	2907 Woodland Av	renue		21	1215			USA	1
	Jera	11. Marital Status	12. Was Decedent Ever Armed Forces?	in U.S. 13.	Was Decedent of His If Yes, specify Cubar	spanic Origi	in? (Specify Yes	or No- 1	4. Race - Ame Black, White	
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great Examinat metal verruings an	d by	3 Widowed 4 Divorced	Year or Dates:							
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event,		17. Father's Name (First, Middle, Last)			unk	18. Mother	's Name (First, M	iddle, Maiden	Sumame)	u
	To Be									
other treumatic	-	19a. Informant's Name/Relationship (7	Type, Print)	19b. Maili	ng Address (Street a	and Number	r or Rural Route A	lumber, City or	Town, State, 2	Zip Code)
Br 1re		Sinai Hospital			l W. Belve	edere				21215
	-	20a. Method of Disposition  1  Burial 2  Cremation 3		Ob. Place of Dispo cemetery, cre-	osition (Name of matory or other place	θ)	Date	20c. Lo	cation - City or	Town, State
ury or		'4 □ Donation 5 M Other (Specify	y in state							
any injury		21 Signature of Funeral Service Licen Ronal a S	Wade? Darec	tor S	2. Name and Addres tate Anat	omy Bo	oard 655	W. Bal	timore	Street
8 O		Lancine /1	10 Class	B	altimore,	MD .	21201			
		23a. Part1. Enter the disease, or com- nock, or heart failure. List only	plications that caused the one cause on each line.	death. Do not en	ter the mode of dying	g, such as c	cardiac or respirat	ory arrest,		Approximate Interval Betweek Onset and Deat
ian		Immediate Cause (Final disease or condition	a acute	pula	many	en	bolisa	$\wedge$		DAY
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ner	Ļ	Sequentially list conditions,	b. Due to for as a co	nsequence of):						
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	ai Examiner	that initiated events	Due to (or as a co							
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funeral director, page 2 should be detached for use as the burial-transit	Certification: To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a co	regnancy [Fetal death 3 [a of death 5 ]]]  2 ER/Outpatie 28b. Time a Injury At home, farm, stopecify)  At home, farm, stopecify)  In (Item 23a) (Type	ont 3 DOA Other (specify)	26. Place er: 4 Nur y at k? Yes 2 N me, date and pinion, deat e number	24a.  1 □ of Death (Check rsing Home 5 □ 28d. Des No 28f. Loca City d place, and due th occurred at the	Did tobacco u  I Yes 2 [ Was an autopsy performed? Yes 2 PNo only one)  Residence cribe how injury tion (Street and or Town, State, othe cause(s) time, date and 29d. Dat	Month  se contribute to  No 3	Day Year  o the cause of death robably 4 □Unkn  utopsy findings avail completion of cause  s 2 □ No  ecify)  Rural Route Number,  s stated. e to the cause(s)

Arno Waserman 05-2565 AKG

> Physicia /Medica Examine

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mential Hygiene. Important: if Itam 27 is marked other than "natural; or Itama 23s or 28a-1 show any injury or other traumatic event. It a Medical Evan not that the retificat

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the buriat-transit

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

For State Registrar		Ce	rtificate of l	Death	0.5	Reg. N	40.	UJ	3582
. Decedent's Name (First, Middle, L	ast)				2. Date Monti	h C	ay	Year	3. Time of Death
Arno Waserman			4b. City, Town, or	L coation of D	Apri		2005 tc. County		11:30 A
a. Facility Name (If not institution, g					Balli	'	+c. County	OI Death	1
969 Western Run  Social Security Number unk 6.		s. last birthday	Baltimo	If Under 24 h	drs. 8. Date	of Birth		9. Birth	place (State or Foreig
	1⊠M 2□F 67		Months Days	Hours M	July	6, Day, Yea	937_	Cou	Land
Sual Residence of Decedent  0a. State 10b. County	10c. 0	City, Town or L	ocation						10d. Inside City Limit
MD		Ва	ltimore						1X Yes 2□N
0e. Street and Number			10f. Zip Code			10g. (	Citizen of	What Co	untry?
5869 Western Run	Drive		2	1215			US	A	
1. Marital Status	12. Was Decedent Ever in	U.S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin?	(Specify Yes	or No-			ican Indian,
1 Never Married 2 Married	Armed Forces? 1 X Yes 2 ☐ No			Specify:	Jeno Hican, eu	J.)		ck, White	
3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🔯 No	зреспу.			Specif	y. W	hite
15. Decedent's (Specify only highest of	Education grade completed)	(Give	edent's Usual Occup e kind of work done	during most of	working l	ınk 16b.	Kind of B	lusiness/l	ndustry ur
Elementary/Secondary (0-12)	College (1-4or 5+) 4	life.	DO NOT use retired	d)					
7. Father's Name (First, Middle, La					Name (First, M	liddle, Maid	en Sumar	ne)	
Izrael Waser	man			Emmy	Loew				
19a. Informant's Name/Relationship		40	ling Address (Street						
Barbara Waserman			205 Woodma	ar Lane					
0a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 3 4 ☐ Donation 5 🛣 Other (Spec	☐Removal from State	o. Place of Disp cemetery, cre	position (Name of ematory or other place	(e)	Date	20c.	Location	- City or	Fown, State
21. Signature   Figure 18 10 S		ur, S	2. Name and Addre	ss of Facility	ard 655	LI D	altin	0.000	Stroot
1/	///// VID -	×				W . D	al LI	lore	Stieet
23a. Part1. Enter the disease, or co		eath. Do not er	Baltimore, nter the mode of dyir	MD 2	1201 diac or respirat	ory arrest,		ore	Approximate
shock, or heart failure. List on Immediate Cause (Final		eath. Do not er	Baltimore, nter the mode of dyir	MD 2	1201 diac or respirat	ory arrest,		nore	
shock, or heart failure. List on	omplications that caused the dely one cause on each line.  Afteros (   Ovo-	eath. Do not er fic Ca	Baltimore, nter the mode of dyir	MD 2	1201 diac or respirat	ory arrest,	aı.cı	lore	Approximate Interval Between
shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	a. Atheroscless Due to (or as a cons	eath. Do not er fic Ca	Baltimore, nter the mode of dyir	MD 2	1201 diac or respirat	ory arrest,		nore	Approximate Interval Between
shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	a. Atherosclevo	eath. Do not en	Baltimore, nter the mode of dyir	MD 2	1201 diac or respirat	ory arrest,		nore	Approximate Interval Between
shock, or heart failure. List on immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, lary lasong to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	a. Atheros (levi- Due to (or as a cons  b. Due to (or as a cons	eath. Do not en	Baltimore, nter the mode of dyir	MD 2	1201 diac or respirat	ory arrest,		nore	Approximate Interval Between
shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, lary Issuing to immediate Cause (Disease or injury	a. Atheros clevo-	eath. Do not en	Baltimore, nter the mode of dyir	MD 2	1201 diac or respirat	ory arrest,		nore	Approximate Interval Between
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shock, or heart failure. List on immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, in the past 12 months? 1   Yes 2   No 9   Unknown  Part II. Other significant conditions:  25. Was case referred to medical examiner?  1   Yes 2   No 27. Manner of Death  1   X   Yes 2   No 27. Manner of Death  1   X   Yes 2   No 27. Manner of Death  1   X   Yes 2   No 27. Manner of Death  1   X   Yes 2   No 28. Manner of Death  1   X   Yes 2   No 29. Manner of Death  1   X   Yes 2   No 29. Manner of Death  1   X   Yes 2   No 29. Manner of Death  1   X   Yes 2   No 29. Manner of Death  1   X   Yes 2   No 29. Manner of Death  1   X   Yes 2   No 29. Manner of Death  1   X   Yes 2   No 29. Manner of Death  1   X   Yes 2   No 29. Manner of Death  1   X   Yes 2   No 29. Manner of Death  1   X   Yes 2   No 29. Manner of Death  1   X   Yes 2   No 29. Manner of Death  1   X   Yes 2   No 29. Manner of Death  1   X   Yes 2   No 29. Manner of Death  1   X   Yes 2   No 29. Manner of Death  1   X   Yes 2   No 29. Manner of Death  1   X   Yes 2   No 29. Manner of Death  1   X   Yes 2   No 29. Manner of Death  1   X   Yes 2   No 29. Manner of Death  1   X   Yes 2   No 29. Manner of Death  2   X   Yes 2   No 29. Manner of Death  2   X   Yes 2   No 29. Manner of Death  2   X   Yes 2   No 29. Manner of Death  2   X   Yes 2   No 29. Manner of Death  2   X   Yes 2   No 29. Manner of Death  2   X   Yes 2   No 29. Manner of Death  2   X   Yes 2   No 29. Manner of Death  2   X   Yes 2   No 29. Manner of Death  2   X   Yes 2   No 29. Manner of Death  2   X   Yes 2   No 29. Manner of Death  3   Yes 2   No 29. Manner of Death  4   Yes 2   No 29. Manner of Death  4   Yes 2   No 29. Manner of Death  4   Yes 2   No 29. Manner of Death  5   Yes 2   No 29. Manner of Death  6   Yes 2   No 29. Manner of Death  7   Yes 2   No 29. Manner of Death  8   Yes 2   No 29. Manner of Death  9   Yes 2   No 29. Manner of Death  1   Yes 2   No 29. Manner of Death  1   X   Yes 2   No 29. Manner of Death  1   X   Yes 2   No 29. Mann	Due to (or as a cons b. Due to (or as a cons b. Due to (or as a cons c. Due to (or as a cons d. Due to	eath. Do not er  Ca sequence of):  s	DEctopic pregnancy Other (specify)  underlying cause grounderlying	MD 2: ng, such as car  yen in Part I.  26. Place of ner: 4 \( \) Nursin yeat k? Yes 2 \( \) No	23e.  24a.  Death (Check ng Home 5 28d. Des 28f. Loca City	Did tobacc  Tyes  Was an autopsy performed Yes 2 (1)  Residence cribe how in the course or Town, Stopped to the cause to the cause to the cause to the cause or the cause to the cause or the cause to t	23d. Da Mo use con 2 □ No 24b. ? No 6 ♣ Ot. njury occur and Num ate)	ate of deliconth  attribute to 3 Province au prior to control death? 1 Yes  ther (Spectred ber or Russianner as	Approximate Interval Between Onset and Death  very Day Year  the cause of death? obably 4 Dunknow topsy findings availate completion of cause of 2 No  city) at scen

State Registrar

31. Date filed (Month, Day, Year) APR 2 1 2005

DHMH 17 Rev 1/2001

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item 5 per fth 9843 5-3-05
State of Maryland P Department of Health and Mental Hygiene Maurice T. Anderson 05-2268 For State Registrar DOS 1-Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Maurice T. Anderson March 30, 2005 2225 p /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Georges Hospital Center Prince Georges Chever1v If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, July 31, 7. Age (In yrs. last birthday) 9. Birthplece (State or Foreign 6. Sex **Funeral** Months ₩M 2□F 30 Washington, D.C. Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10h County 10a. State 28e-1 show Oxon Hill other traumatic event, the Madical Examinar must be notified at Maryland Prince George's 1DXYes 2 □ No Director 10g. Citizen of What Country? U.S.A. 10e. Street and Number 10f. Zip Code 5 20745 1016 Marcy Avenue #T-1 items 23a death Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "netural; or item any injury or other traumatic event, the Madical Experient once. 1 Never Married 2 Married Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Self employed Truck Driver 18. Mother's Name (First, Middle, Maiden Sumame)
Michelle Anderson 17. Father's Name (First, Middle, Last) Be Thomas Geddie ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Alumber or Rural Route Number, Gity or Town, State Zip Code) 1016 Marrcy Avenue #I-I Oxon Hill, Marryland 20745 Mrs. Tanya E. Anderson (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Gurial 2 ☐ Cremation 3 ☐ Removal from State April 7, 2005 Clinton, Maryland ' 4 ☐ Donation 5 ☐ Other (Specify) Resurrection Cenetery 22. Name and Address of Facility 21. Signature of Funeral Pervice Licenses Rollins Funeral Home, Inc. 4339 Hunt Place, N.E. Washington, D.C. of. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Multiple sunshot wounds Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transi and Due to (or as a consequence of): attending physician Box 68760, Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ♠No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 A Yes 2 □ No 24a. Was an autopsy performed? certificate 1 Yes 2 ☐ No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1X Yes 2 □ No this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 Natural subject was shot 1 ☐ Yes 2 No 3-30-65 9:56 2 Accident after death Director; 28f. Location (Street and Number or Rural Route Number, City or Town, State) 5355 Quincy Struct 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by determined 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 XMedicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Street hin 24 hours a 29a. Certifier Medical (Check only one) within To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 0 hi March 31, 2005 OCME

2 State

LING 31. Date filed (Month, Day, Year)
APR 0 8 2005

CI

111 Penn Street Baltimore, Maryland 21201 2. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

			1 - State of Maryland / Dep	partment of Fertificate of			iene g. No. 2005	13584
	Physici		1. Decedent's Name (First, Middle, Last) James Ashton			2. Date of Death Month April 1,	Day Year	3. Time of Death 10:32 🎁 . n
	/Medic Examin		4a. Facility Name (If not institution, give street and number)  3815 Holloway Circle  5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)	Upper M		8. Date of Birth	4c. County of Deat Prince Ge	eorge's
	Director		224 44 3864 1⊠M 2□F 68 Yrs.  Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or 1	Months Days	Hours Min	Jan. 21,	1937 Virg	ginia  10d. Inside City Limits
	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Heatth and Mental Hygiene. If item 27 is marked other than "natural", or items 23s or 28s-f show or other traumatic event, the Medical Examinar must be notified at	al Director	Maryland Prince George's Upper  10e. Street and Number  3815 Holloway Circle	Marlboro 101. Zip Code	20772		og. Citizen of What Co USA	1√2 Yes 2 No
9036	ours after dea iral', or items	d by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Married  1 Never Married 2 Narried  1 Narried Narried Narried  1 Narried Narried Narried  1 Narried Narried Narried  1 Narried Narried Narried Narried  1 Narried Narried Narried Narried  1 Narried Na	. Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 ☐ No			14. Race - Ame Black, White Specify: Bla	e, etc. ack
21215-0036	e filed within 72 h al Hygiene. I other than "natu vent, Ire Medical	Completed	(Specify only highest grade completed) (Given the first state of the f	edent's Usual Occup re kind of work done DO NOT use retire Supervisor	during most of wo	orking	Government	
Maryland	2 should be file and Mental Hy is marked oth raumatic event	To Be	17. Father's Name (First, Middle, Last)  Gattly Ashton		Anni		shton	
	ss 1 and 2 sho of Health and item 27 is my other traums		Gayle Ashton/daughter  20a Mathod of Disposition 20b. Place Obstacle	Taylor	Town RD	Montross	City or Town, State, 2 VA 2252 Oc. Location - City or	0
altimore,	t. Parturant		1  Burial 2  □ Cremation 3  □ Removal from State  '4  □ Donation 5  □ Other (Specify)  Galilee		ırch Cem.		ontross, V Funeral Ho	
B	permi Depa Impo any ir		23a, Part 1. Enter the disease, or complications that caused the death. Do not e	4308 Suit	land Roa	d Suitlan	d, MD 207	
>	Physician /Medical		shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):	lancer			1	Onset and Death
	Examiner sician and purial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of):  c					
8760,	icate be e physician s the buris	dical						
O. Box 6	that the death certificate be executed ted by the attending physician and detached for use as the burial-transit	Physician/Med		☐Ectopic pregnanc	ey .		23d. Date of del Month	ivery Day Year
rds, P.	ires sigr d be	ρĺ	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause gr	ven in Part I.		acco use contribute to s 2 □ No 3CXPr	
Vital Records,	The law ate has b page 2 s	Completed				24a. Was ar autopsy perform 1 Yes X	prior to death?	stopsy findings available completion of cause of
of Vit	Physician: 1 this certifical ral director, p	To Be	25. Was case referred to medical examiner?  1   Yes XX No	BILL SELECT	her: 4 🗌 Nursing	Home ST Reside	nce 6 Other (Spec	cify)
Division	tending leath. tor: After the fune	Certification:	XX Natural 5 ☐ Pending investigation 3 ☐ Suicide 6 ☐ Could not be determined 4 ☐ Homicide (Month, Day Year) Injury - At home, farm, so building, etc. (Specify)	M 1 [	]Yes 2 □ No		eet and Number or Ru	ıral Route Number,
Ö	spital lours neral		29a. Certifier XXCertifying Physician: To the best of my knowledge, der (Check only 2 Medical Examiner: On the basis of examination and/or	ath occurred at the ti	ime, date and plac	e, and due to the ca	use(s) and manner as	stated.
	To the Ho within 24 h To the Ful	Medical	one) and manner stated.  29b. Signature and title of certifier	29c. Licens			d. Date signed (Month	
G	p (10)		30. Name and address of person who completed cause of death (Item 23a) (Typ.		28079		April 06,	2005
	Str	to.	Francine Higgs-Shipman, M.D. 11	700 Belts	sville Dr	. Beltsvi	lle, MD	
	Regist		31. Date filed (Month, Day, Year)  APR 9 8 2005	and the				

			For State Registrar		State of I	Marylan		artmen rtificate			and M	-	giene Reg. No	005	130	85
	Physici	an	1. Decedent's Name (F									2. Date of De	Day	Year	3. Time of 985	
	/Media	al.	GEORGE R			er)		4b. City.	Town, or	Location of	of Death	April	2 4c. Co	2005 ounty of Death		D. "
	Examir	ier	Memo		Hospi			8		tor			-	Talb		
	Funeral		5. Social Security Num		Sex 7.	Age (In yrs. 81	last birthday)	If Under Months	1 Year Days	If Under	24 Hrs. Min.	8. Date of Bird (Month, Da OCT 3,	th y, Year)	9. Birth	place (State o	
	Director		Usual Residence of De		X W ZU	01	Yrs.					OCT 3,	1923	UNI	TED KIN	NGDOM
	yland how			Ob. County		10c. Cit	y, Town or Lo	ocation							10d. Inside Ci	•
	Ba-fs	Director	MD	TALBO	T		EAST								1 🗌 Yes	XIX No
	with th		10e. Street and Number					10f. Zip		601			-	n of What Cou		
	ns 234	Funerai	26698 AR	CADIA S	HORES RD	ent Ever in U	.S. 13.	Was Deced		601 spanic Orio	gin? (Spe	ecify Yes or No Rican, etc.)		ED KINO		
ထ္	be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or itams 23a or 28a-1 show event, I're Madical Examinar must be notified at	/ Fun	1 Never Married		Armed Force 1 Tes 2 If Yes, Give			lfYes,spec 1 □ Yes :		n, Mexican Specify:	, Puerto	Rican, etc.)		Black, White,	etc. HITE	
215-0036	ural',	d by	3 Widowed 4 [		Year or Date	s:		dent's Usua						of Business/Ir		
7	in 72 n "nat	Completed	(Specify	only highest gra	ade completed)	or F.)	(Give	kind of wor DO NOT us	k done d	uring most	t of worki	ing	100. Kina	OI DUSINGSS/II	loustry	
212	giene giene er tha	mo	Elementary/Seconda	ary (0-12)	College (1-4 5+	UI 5+)	PF	RESIDE	NT				MA	NUFACT	JRING_C	
	be filed ital Hygi id other event, II	Be	17. Father's Name (Fir									(First, Middle.				
Maryland	should be filed withir and Mental Hygiene. I markad other than umatic event, ILE M.	<sup>c</sup>	GEORGE G		COWLAND B.	ARKER	10h Maili	na Addross	(Street a			LILICO			o Code)	
Z Z	and 2 she salth and n 27 is m		DONNA BAR					•				RD., EA			-	
re,	es 1 ar of Hea fitam r other		20a. Method of Dispos		75 1/ 6	1 .	 Place of Dispo cemetery, crea	sition (Nan	ne of ther place	9)	E	Date	20c. Loca	tion - City or T	own, State	
altimore,	Pages nent of ant: If its ury or o		1 ☐ Burial 2 <b>人</b> 0 1 ☐ Donation 5		Removal from Sta fy)	310	_				rr.	4-3-200	5 ST	EVENSV	ILLE, M	1D
Balt	permit. Pages 1 and 2 should Department of Health and Men Important: if item 27 is marka any injury or other traumatic <u>once.</u>		21. Signature of Fune		strough (	r ISA	0 F		IS, H	ELFE	NBEI	N & NEW			HOME E	A
		-	23a. Part 1. Enter the	disease or com	nlications that cau	sed the deat		200 S. ter the mod	HAR e of dying	RISON g, such as	N ST cardiac	EASTON or respiratory as	, MD rrest,	21601	Approximate	е
	Physician		shock, or heart to Immediate Cause (Fir disease or condition		Muc	n line.	hal	Inf	dre	hon	)				Onset and I	
	/Medical		resulting in death)	-	Due to (or	as a conseq	uence of):	-1.		ALON					V ~	_
В	Examiner	<u></u>	Sequentially list condi	tions,	b	as a conseq		rter	y I	iseo	y se				Jeans	
	t insit	Examiner	Cause, Enter Underlyi Cause (Disease or inju	ng	500 10 (0)	45 4 0011504	301100 01).									
o	be executed sician and burial-transit		that initiated events resulting in death) Las	t I	Due to (or	as a conseq	uence of):									
8760	icate be physicii s the bu	dicai		•	d											
ox e	leath certific attending pl	/Me	IF FEMALE:		23c. If yes, outco	me of pregna	ancy						230	d. Date of deliv	erv	
B.	death e atten d for u	ician	23b. Was decedent pr in the past 12 mo 1 Tes 2 Tes	onths?	1 ☐ Live birtl 4 ☐ Pregnan	t at time of d		□Ectopic pr □ Other <i>(sp</i>						Month		/ear
0	at the de by the a	Physician/Med	9 🗆 Unknown		9□ Unknow											
Records, I	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	by	Part II. Other significa	via			ulting in the u	nderlying c	ause give	n in Part I.			obacco use Yes 2 🗆 i	contribute to	,	leath? Inknown
ecc	e law re has be je 2 sh	Completed	Gast	rointes	tinal B	leed						24a. Was autop	osy	24b. Were auto	opsy findings a empletion of ca	available ause of
			Pros	tote	Concer							1 ☐ Yes	rmed? 25 No	death?	2 No	
Viita	Physicien: Th rthis certificate ral director, pag	o Be	25. Was case referred examiner?  1 Yes 2 No		Hospital:	ationt 2	ER/Outpatier	nt 3 DC	Othe	-		n <i>(Check only o</i> me 5 ☐ Resid		Other (Speci	6v)	
ō	g Physer this eral di	n; To	27. Manner of Death		28a. Date of		28b. Time o		8c. Injury Work			28d. Describe I			777	
jou	Attending Predath. sctor: After Iby the funera	atio	2 Accident	5 Pending investigatio	n	Day roar,	mary	М		res 2 🗆 I						
Division of	l or Attendater deatl Director:	Certification;	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of	Injury - At he , etc. (Specif	ome, farm, str y)	reet, factory	, office			28f. Location (5 City or Tov	Street and f vn, State)	Vumber or Rur	al Route Num	ber,
	To the Hospital within 24 hours a To the Funeral Completely filled	dicai Ce			nysician: To the be											. =
	the H nin 24 the F nplete	Medi	one)		and manne				License					signed (Month,		
	or wit	-	29b. Signature and titl	or Cartiner	en						67		. 1	. i		
1			30. Name and address	s of person who	completed cause	of death (Iter	n 23a) (Type.	Print)			- /		- 1	1		
1	5)		607 DUT	CHMA	NS LA	WE,	EAST	no	nu	0,2	160	DAN	MAN	Sook	al M	( D.
1	Sta Registi		31. Date filed (Month,	Pay, Year) 20	32 90	istrar's Signa	ature									
- 2	TEUISI	1 - 1			X 77 5 5 6 6		530	AND DESCRIPTION OF THE PERSON								

			For State Registrar	State of	Marylar		artment rtificate			and M	lental Hy	giene Reg. No.	200			586
	Physici	an	1. Decedent's Name (First, Middle,	Last)	o Ditn	or					2. Date of De Month	ath Day		ear	3. Time of 093	
	/Medic		4a. Facility Name (If not institution,			er	4h City	Town or	Location o	of Death	April	6	200 County of I		030	
	Examin	er	Union Hospit			ntv	4b. City,		kton	) Deau		40. 0	•	Ceci	1	
						last birthday)	If Under		If Under	24 Hrs.	8. Date of Birt	th		Birthol	ace (State o	or Foreian
н	Funeral Director		219-12-9788	1 ☐ M 2 🔀 F	80	Yrs.	Months	Days	Hours	Min.	(Month, Da Aug. 20	y, Year)		Coun	ny) Maryla	
			Usual Residence of Decedent						3							
	ylan		10a. State 10b. County		10c. Ci	ty, Town or Lo	ocation							10	Od. Inside Ci	
	B Ma	ç	Maryland Cec	il				Ris	ing S	Sun					1 ⊠ Yes	2   No
	or 28	Director	10e. Street and Number				10f. Zip	Code				10g. Citize	en of Wha	t Coun	try?	
	within 72 hours after death with the Maryland ene. than "naturai", or items 23a or 28a-f show is Medical Execution mast be notified at		132 Sharon Stre						219					S.A.		
	r deg	by Funeral	11. Marital Status	12. Was Deced Armed Ford	es?	.S. 13.	Was Deced If Yes, spec	lent of Hi	ispanic Orig n, Mexican	gin? (Spe	ecify Yes or No Rican, etc.)	- 14	4. Race Black, \			
36	or it	Y.F.	1 Never Married 2 Marrie	If Yes, Give			1 ☐ Yes 2	2⊠ No	Specify:			8	Specify:	TAZ	hite	
Ö	hour	d b	3 X Widowed 4 □ Divorced	Year or Date	es: 	160 Dass	dent's Usua	1.000.00	etian .			16h Vin	d of Busin			
5	"nat	Completed	15. Decedent's (Specify only highest	grade completed)		(Give	kind of wor DO NOT us	rk done a	turing most	t of work	ing				ving G	roun
7	withi ene. than	щ	Elementary/Secondary (0-12) Twelve Years	College (1-4	lor 5+)		Punch C			Secret	tary	Aberd	leen,	Ma	ryland	i
ე ე	filed Hygi ther ent, I		17. Father's Name (First, Middle, L.	ast)					18. Mothe	r's Name	e (First, Middle,	Maiden S	iumame)			
lan	d be Bental Ked o	To Be		Chester Ja	ckson						Franc	es Mu	irphy			
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hyglene. Item 27 is marked other than "natural, or items 23a or 28a-f show other traumatic event, I've Medical Execution inserting the notified all	-	19a. Informant's Name/Relationshi	p (Type, Print)		19b. Maili	ng Address	(Street a	and Numbe	or or Run	al Route Numbe	er, City or	Town, Sta	te, Zip	Code)	
	nd 2 lith ai 27 is r trau		Wayne Bitner (se	on)		2635	Red I	Coad	Road	, Ri	sing Su	n, Ma	aryla	nd	2191	11
ē,	s 1 al f Hea item othe		20a. Method of Disposition			Place of Disponentery, cre	osition (Nan	ne of	a)	[	Date	20c. Loca	ation - Cit	y or To	wn, State	
30	Page ent of ht: If		1 ☑ Burial 2 ☐ Cremation : 4 ☐ Donation 5 ☐ Other (Spe		ate	ookvie				04/0	9/05	Risi	ng Si	ın,	Maryl	and
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra once.		21. Signature of Funeral Service		0		2. Name an									
ä	Depuil Depuil Import		Marian	ratters	e }	1 -	ee A. erryvi				Son Fun			e, F	. A.	
			23a. Part1. Enter the disease, or of shock, or heart failure. List of	omplications that car	used the dear	th. Do not en	ter the mode	e of dying	g, such as	cardiac (	i <del>d 2190</del> or respiratory a	rrest,	50		Approximat Interval Bet	e ween
	Pnysician :		Immediate Cause (Final disease or condition	The	AT 1810.	. 1	L	5000000	1000	. c	A L			1	Onset and I	
	/Medical		resulting in death)	aDue to (o	r as a consec		thev	rys	m	0 Y	nunta			1	_ m	DOTAYS.
	Examiner			Th	orac	-	tont	a.	Dis	Sec	tion	A state of two		13	day	5.
	7 =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (o	r as a consec	quence of):				,					25	
	nd rans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	с												
0	e exe		resulting in death) cast	Due to (o	r as a consec	quence of);										
8760,	icate be executed physician and s the burial-transit	dical	'	d			-							-		
9	ertific fing p	/Me	IF FEMALE:	23c. If yes, outco	ome of pream	2004										
Вох	ath c attend for us	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birt	th 2 Feta nt at time of c	al death 3[	Ectopic pro					23	3d. Date o Month			Year
o.	the shed	ysic	1 ☐ Yes 2 🔀 No 9 ☐ Unknown	9□ Unknov		294((1) 5(	_ Other (Sp	ecily)								
σ.	The law requires that the death certificate has been signed by the attending to agge 2 should be detached for use as	P.	Part II. Other significant condition	is contributing to dea	th but not res	sulting in the u	inderlying ca	ause give	en in Part I.		23e. Did t	obacco us	e contribu	te to th	e cause of d	leath?
Records,	w requires that been signed t should be det	d by	COPD H	ly porteno	100	Prot	re UI	car	Dise	Se	1 🗇 🕆	Yes 2	No 3	Probi	ably 4 🗆 l	Jnknown
Š	v requ	Completed	0-1	, 1							24a. Was	an	24h Wer	e autor	sy findings	available
Rec	has ge 2	Ę	Ustro poros	3							autop	rmed?	prio dea	tb con	npletion of c	ause of
a			or late and a section									2 No	1 🐼	Yes	2 No	
Vital		o Be	25. Was case referred to medical examiner?	Hospital:	0 T	150/0-##i-		Othe	DE.		h <i>(Check only c</i> me 5 □ Resid		Cothes (	·C/4		
oţ		<b>-</b>	1 Yes 2 No  27. Manner of Death	28a. Date of	Injury	ER/Outpatie		8c. Injury	/ at		28d. Describe I			Specify	)	
On	ding Ph th. After th funeral	tlor	1 Natural 5 Pending 2 Accident investig		, Day Year)	Injury	м	Work	k? Yes 2⊟	No						
Division	Attending ir death. ector: After by the fune	ertification;	3 Suicide 6 Could no	ot be 28e. Place o	of Injury - At h	ome, farm, st	reet, factory	, office			28f. Location (		Number	r Rura	Route Num	iber,
<u>S</u>	n it of	ert	4  Homicide	building	g, etc. (Speci	ty)					City or Tov	vn, State)				
	Hospitai or 24 hours afte Funeral Dir tely filled in	al C		Physician: To the b												
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	edica	(Check only 2 Medical E	xaminer: On the bas and manne		ation and/or in	vestigation,	, in my of	oinion, dea	th occur	red at the time,	date and p	olace, and	due to	tne cause(s	.)
	To the To the To the COMP	Me	29b. Signature and title of certifier	1.1.1			29c	. License	number			29d. Date	signed (A			
}	1		JOHN K	. Weiche	x (1)	r NO		Do	044	373		4	181	200	35	
	0			no completed cause									ı			
	0		Joseph K. Weidn				olonia	al W	ay, R	isin	g Sun,	Mary]	Land	2	1911	
	Sta	ite	31. Date filed (Month, Day, Year)	32. Re	gistrar's Sign	ature										

			1 - For State Registrar	State of	Marylan		artment of H			Re	g. No. UU5	135	87
	Physici	an	Decedent's Name (First, Middle, L.	ast)					2.	Date of Death Month	n Day Year	3. Time of	
	/Medic		Harold	F .		Barke				pril 8	3, 2005	8:55	A <sup>M</sup>
	Examin	er	4a. Fecility Name (If not institution, gi				4b. City, Town, or		of Death		4c. County of Dea	ith	
			Sunbridge Care 5. Social Security Number 6.		ng Hon 7. Age (In yrs.		Elkto	n If Under:	24 Hrs. 8.	Date of Birth	Cecil 9.Bi	thplace (State of	r Foreian
	Funeral Director		171-10-4028	1∭M 2□F	90	Yrs.	Months Days	Hours	Min.	(Month, Day, ay 28,	Year) C	ountry) ester,	_
	ס		Usual Residence of Decedent							2, 20,	<u> </u>		
	uylan show	_	10a. State 10b. County		10c. Cit	y, Town or Lo	ocation					10d. Inside Cit 1 ☐ Yes	
	88-15	Director	DE New Ca	stle	Bea	ar	T =					<u> </u>	-72.10
	with the		10e. Street and Number				10f. Zip Code			100	Og. Citizen of What C	ountry?	
	eath v	eral	117 Farmhouse		dent Ever in U	S 13	Uas Decedent of H		gin? (Specif	v Yes or No-	USA 14. Race - Am	erican Indian,	
	ter d	Funeral	1 Never Married 2 Married	Amed For	rces?		Was Decedent of H If Yes, specify Cuba	n, Mexican	, Puerto Ric	an, etc.)	Black, Wh		
98	urs a	<b>百</b>	3	If Yes, Giv Year or Da	•	941	1 ☐ Yes 2 ☐ No	Specify:			Specify:	White	
21215-0036	J within 72 hours after death with the Maryland sien. Jene. Than "natural", or Items 23s or 28s-f show the "Maryleal Evarainer must be rediffed at	Completed	15. Decedent's E (Specify only highest g			(Give	dent's Usual Occup	during most	t of working	1	16b. Kind of Business	/Industry	
2	within ene. than	dr.	Elementary/Secondary (0-12)	College (1	-4or 5+)	`life.	DO NOT use retired	0					
2	a filed w Il Hygier other tl vent, Ib		17. Father's Name (First, Middle, Las	t)		Lab	Techni		er's Name (F	irst Middle M	Chen (aiden Sumame)	ical	
⊑	ed at be €	Be	Thomas Barker	.,						ie Cha			
2	s 1 and 2 should be f Health and Menta Item 27 is marked other traumatic ev	္	19a. Informant's Name/Relationship	(Type, Print)		19b. Maili	ng Address (Street				City or Town, State,	Zip Code)	<del></del>
<u>R</u>	and 2 s ealth an m 27 is ner trau		Alice Cahall	(-3)		F					DE 1970		
ō,	s 1 an f Heal ftem 2 other		20a. Method of Disposition			Place of Dispo	esition (Name of matory or other place		Date		Oc. Location - City o		
Ę	Page ent o nt: If ry or	1	X☐XBurial 2 ☐ Cremation 3   `4 ☐ Donation 5 ☐ Other (Spec		State Sp	ringf	ield Cemete:	rv	4/13	/05 S	pringfie	ld, PA	
Baltimore,	permit. Pag Department Important: any injury once.		21. Signature of Filneral Service	ntee	1 - 1 - <del>1</del>	2:	<ol><li>Name and Addres</li></ol>	s of Facilit	ty				
Δ	20 E 20		23a. Part1. Enter the disease, or cor	Ww.	CC04	$42 \frac{8}{2}$	eeson Me 053 Pul:	emor: sadk:	ial S <del>i Hi</del> q	hway,	es <del>Newark,</del>	DE 19 Approximate	702
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	nplications that co one cause on e	sed the deat ach line.	h. Do not en	er the mode of dyin	g, such as	cardiac or re	espiratory arre	st,	Approximate Interval Betv Onset and D	ween
	hysician		Immediate Cause (Final disease or condition	- a the	perten	sive	Ronal D.	isaas	و			unknow	
	/Medical Examiner		resulting in death)	Due to	or as a conseq	uence of):							
		<u></u>	Sequentially list conditions,	b. Due to (	or as a consuc	UNITED UT	e						
	uted    -  -	m in	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	·	·								
Ć,	execu in and ial-tra	Examine	that initiated events resulting in death) Last	CDue to (	or as a conseq	uence of):					<del></del>		
8760,	death certificate be ехесиted e attending physician and ad for use as the burial-transit	edical	•	d									
89	leath certifica attending ph I for use as th	Med	IF FEMALE:									1	
Вох	ath ce ttendi or use	lan/I	23b. Was decedent pregnant in the past 12 months?		irth 2∐Feta	Ideath 3[	Ectopic pregnancy				23d. Date of de Month	,	'ear
Ö	he des	Physician/M	1 🗆 Yes 2 🗆 No 9 🗆 Unknown	4∐Pregn 9□Unkno	ant at time of down	eath 5L	Other (specify)						
P.O.	law requires that the de as been signed by the a 2 should be detached i		Part II. Other significant conditions	contributing to de	eath but not res	ulting in the u	nderlying cause give	en in Part I.		23e. Did toba	acco use contribute (	o the cause of de	eath?
ds,	uires Isign Id be	d by								1 ☐ Yes	s 2 □ No 3 □ P	robably 4 🗹	Inknown
Ö	w requires that been signed to should be det	Completed								24a. Was an	24b. Were a	utopsy findings a completion of ca	available
Re	o ~ o	mo								autopsy perform 1  Yes 2	ed?   death?	completion of cases 2 No	tuse of
	ician: Th certificate rector, paç	0	25. Was case referred to medical					26. Place	of Death (C	Check only one			
>	<b>y</b>	To B	examiner? 1 ☐ Yes 2 ☑ No		-	ER/Outpatie		4 Nu			nce 6 □Other (Spe	ecify)	
0	Jing Pt J. After tt funeral		27. Manner of Death  1 ☑ Natural 5 ☐ Pending	28a. Date of	of Injury h, Day Year)	28b. Time o Injury	Worl			d. Describe how	w injury occurred		
sio	Attending ir death. ector: After by the fune	cat	2 Accident investigate 3 Suicide 6 Could not		-4 lain At la			Yes 2 □ I		Location (Sta	eet and Number or F	ural Route Num!	her
5	or Attenater deat Director: in by the	Certification;	4 Homicide determine	4 200. Flace	ng, etc. (Specif	y)	reet, factory, office		201	City or Town,		ara, i robio rvanic	,,,
_	Hospital		29a. Certifier 1 Certifying F	hysician: To the	best of my kno	wledge, deat	h occurred at the tin	ne, date an	d place, and	d due to the ca	use(s) and manner a	s stated.	_
	To the Hospital or Attending Phewithin 24 hours after death.  To the Funeral Director: After the completely filled in by the funeral	edical	(Check only 2 Medical Exe	miner: On the ba and mann	asis of examina	ition and/or in	vestigation, in my o	pinion, dea	th occurred	at the time, da	te and place, and du	e to the cause(s)	
	To the within 2 To the comple	Me	29b. Signature and title certifier				29c. Licens			29	d. Date signed (Mon		
			> Jacko	ers ni	7		D008	2332	2_		4.8.05		
	5		30. Name and address of person who	completed caus		4	Print)	RI	POLT	m Mx	2/92/		
	-01		31. Date filed (Month, Day, Year)	32. R	1/8 No		our o	9 6	-20	7) "	- 14		
	Sta Registr		APR 1 1 2005	Kenn	BA	menter of							

DHMH 17 Rev 1/2001

JUCK, Nathanie,

		_	For State Registrar	State of Mary		artment of Hetificate of L		R	eg. No. 4 UU 5	13589
	Physici	an	Decedent's Name (First, Middle, La	-				2. Date of Dea Month	Day Year	3. Time of Death
	/Medic		LaVerge Lee Ca					April	6 2005	9:30am M
	Examin	er	4a. Facility Name (If not institution, give 640 Mecklenburg	,	202	4b. City, Town, or	ton	1	4c. County of Dea	
					yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	Talbot	
l	Funeral Director			1 M 2 🔀 F	95 Yrs.	Months Days	Hours Min.	Nov. 22	, 1909 PA	thplace (State or Foreign ountry)
	land ow		10a. State 10b. County	10	c. City, Town or Lo	cation				10d. Inside City Limits
	Man,	ţ	MD Talbot		Easton					1 ☐ Yes 2 🙀 No
	r 28a	rec	10e. Street and Number			10f. Zip Code		1	log. Citizen of What C	ountry?
	h with	Funeral Director	640 Mecklenburg	Ave., Apt. 2	202	21601			USA	
	dea	ner	11. Marital Status	12. Was Decedent Eve Armed Forces?	r in U.S. 13.	Was Decedent of His f Yes, specify Cubar	spanic Origin? (S	pecify Yes or No-	14. Race - Ame Black, Whi	
õ	or it	Y Fu	1 Never Married 2 Married	1 ☐ Yes 2 ☑ No If Yes, Give		1 ☐ Yes 2 🛣 No	Specify:		Specify: W	
21212-0036	uret',	d by	3 ☐ Widowed 4 🙀 Divorced	Year or Dates:		955				
7	within 72 hours after death with the Maryland ene. then "neture!", or liems 23e or 28e-f show the Moded Exacilies must be hollified at	Completed	15. Decedent's E (Specify only highest gr		(Give	lent's Usual Occupa kind of work done d DO NOT use retired)	uring most of wor	king	16b. Kind of Business	/Industry
7	withir ene. then	E C	Elementary/Secondary (0-12)	College (1-4or 5+)		sperson			Retail	-
	filed Hygi ther ant, 1	ပိ	17. Father's Name (First, Middle, Las	1)	Dare	_	18. Mother's Nan	ne (First, Middle,	Maiden Sumame)	
<u>a</u>	d be id be i	To Be	Robert G. Lee				Effie K	aveor		
Maryland	mat mat	-	19a. Informant's Name/Relationship	(Type, Print)	19b. Mailir	g Address (Street a			r, City or Town, State,	Zip Code)
	nd 2 aith a 27 is r tre		Dr. Jack Canady/	Son	9255	Honeysucl	kle Driv	e. Easto	n. MD 216	01
ē,	item item		20a. Method of Disposition	2	20b. Place of Dispo				20c. Location - City or	
Ë	Page lent c nt: If ry or		1 🔀 Burial 2 □ Cremation 3 [ '4 □ Donation 5 □ Other (Speci		-	-		9/2005	Stevensvil	le. MD
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel; or items 23a or 28a-f show any injury or other treumatic event, the Modical Examination at the nutilised at ODGe.		21. Signatifie of Foneral Service Lies		. 22	. Name and Addres	s of Facility			Home, P.A.
			23a. Pan1. Enter the disease, or con	no ication and caused the						Approximate
			23a. Pan 1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final	one came on each line.		10/2 /	. K	[ ]		Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Due to (or as a co	ange	ru yea	177 - 1	61/KI		ZWKS
	Examiner			Due to (or as a co	onsequence on.					
ı.		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a co	onsequence of):					
	cuted od ransit	Examiner	that initiated events	c.						
ĵ	an ar an ar irial-t	EX	resulting in death) Last	Due to (or as a co	onsequence of):					
8760,	The law requires that the death certificate be executed tte has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Ical		d						
9	ing ph	Physician/Medi	IF FEMALE:							
XOR	eath certific attending p for use as f	an/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of p	Fetal death 3	Ectopic pregnancy			23d. Date of de Month	livery Day Year
0.	the a	sici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at tim 9□Unknown	e of death 5	Other (specify)				
<u>.</u>	that the death ned by the atter detached for u	Ph	Part II. Other significant conditions	contributing to death but n	ot resulting in the	nderwing cause give	n in Part I	23a Did to	bacco use contribute to	o the cause of death?
Š	ires tha signed I be det	ğ	/) /0	betor M	1/1/4v	/ Contyring Calasti give	arrivate.	1 🗆 Y		robably 4 Unknown
Vital Records,	w requir been si should l	etec	^	- then				044 1464	045 344	
ě	has has ge 2 s	Completed		23 / 10 00 00				24a. Was a autops perfori	sy prior to	utopsy findings available completion of cause of
<u>=</u>								1 ☐ Yes	2₽No 1□Yes	5 2□ No
=	sicier certif recto	o Be	25. Was case referred to medical examiner?	Hospital:		t 30 DOA Othe	-	th (Check only or		
ō	Physicien: r this certifica ral director, p	<del> </del>	1 Yes 2 No  27. Manner of Death	1 Inpatient 28a. Date of Injury	2 ER/Outpatier	I SU DUA	4   Ivuising n		ence 6 Other (Spe	ocify)
on	ding In. h. After funer	tlor	Natural 5 Pending 2 Accident investigation	(Month, Day Ye	ear) Injury	28c. Injury Work M 1 □ Y	? ′es 2 □ No			
Division	f or Attending after death. Director: After In by the fune	flca	3 Suicide 6 Could not	28e. Place of Injury	- At home, farm, str	eet, factory, office			treet and Number or R	ural Route Number,
5	after after Dire	Certification:	4 Homicide	building, etc. (5	Specify)			City or Town	n, State)	
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funer	edical C	29a. Certifier 1 Certifying P (Check only one)	hysician: To the best of m miner: On the basis of ex- and manner stated	amination and/or in	n occurred at the tim vestigation, in my op	e, date and place inion, death occu	, and due to the c rred at the time, d	ause(s) and manner a late and place, and du	s stated. e to the cause(s)
	To the P	Mec	29b. Signature and title of certifier	and manner states		29c. License	number	2	29d. Date signed (Moni	th, Day, Year)
	F 3 F 8		JAM	5//	ND	1)2	5750		4-7-00	
			30. Name and address of person who	completed cause of death	h (Item 23a) (Tyne.			7.		
1	BICK		Robert Sanchez M	· ·			on, MD	21601		
	Sta	ate	31. Date filed (Month, Day, Year)	32. Register's	Signature	4				
	Regist	rar	APR -	8 2005 See	we &	Cooke				

		1 - For State Registrar	State of Marylan	-		of Health ar of Death		Reg. No.	005	135	90
Physic	cian	Decedent's Name (First, Middle, Last)					2. Date of De Month	ath Day	Year	3. Time of	
/Med	ical	THOMAS MICHAEL C.  4a. Facility Name (If not institution, give s			4h City Toy	vn, or Location of	April	5	2005 County of Death	7:45	PM <sup>M</sup>
Exam	iner	Genesis HealthCa	· ·	ines		Caston			m 11		
Funera Directo		227-48-7728	7. Age (In yrs. 67	last birthday) Yrs.	If Under 1 Y Months D	ear If Under 24 ays Hours	8. Date of Bi (Month, Da SEPT •	th 1 <i>y, Year)</i> 20 1	9. Birth <i>Co</i> u 9. MAJ	place (State on ntry) RYLAND	r Foreign
land land		Usual Residence of Decedent  10a. State 10b. County	10c. Cit	y, Town or Lo	cation					10d. Inside C	ity Limits
Mary Hahe	ţō	MD TALB	ОТ	ST. MI	CHVELG					1 ☐ Yes	XXNo
h the	Director	10e. Street and Number	O.L.	DI. HI	10f. Zip Co	de		10g. Citiz	en of What Cou	intry?	
th wit	a D	213 TYLER AVE.			21	663			AZU		
er dea	Funeral		12. Was Decedent Ever in U Armed Forces?		Vas Decedent Yes, specify	of Hispanic Origi Cuban, Mexican,	n? (Specify Yes or No Puerto Rican, etc.)	)- 1	4. Race - Ameri Black, White		
and 21215-0036  be filed within 72 hours after death with the Maryland ital Hygiene. Indicate than "neturel", or items 23a or 28e-1 show event, the Medical Examinar must be indifficated.	by Fi	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1	□Yes 21	No Specify:			Specify: W	HITE	
21215-0036  Solve within 72 hours affigiene.  Ber than "neturel; or the Medical Exami	ted	15. Decedent's Educ (Specify only highest grade		16a. Deced	lent's Usual O	ccupation	of working	16b. Kin	nd of Business/Ir	ndustry	
within than "than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	`life. L	OO NOT use r	etired)	SI WORKING				
nd 2121 e filed within al Hygiene. other than vent, the Me		12 17. Father's Name (First, Middle, Last)	1	SYS	TEMS A		s Name (First, Middle		PATENT	OFFICE	<u> </u>
Maryland nd 2 should be fili th and Mental Hy 27 is marked oth	To Be	MAURICE F. CAVANA	UGH				ANCES BRAI		Sumame)		
re, Marylar s 1 and 2 should be f Health and Menta item 27 is marked other traumatic ev	-	19a. Informant's Name/Relationship (Type		19b. Mailin	g Address (Si		or Rural Route Numb		Town, State, Zi	p Code)	
		AUDREY R. CAVANAU					MICHAELS,				
Baltimore, permit. Pages 1 a Department of Hes important: if item		20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Re		Place of Dispos cometery, cren			Date	20c. Loc	cation - City or T	own, State	
ti Pa		'4 □Donation 5 □ Other (Specify)					R. 4-6-200	5 S'	TEVENSV	ILLE, N	<u>1D</u>
Baltimor		21. Signature of Funeral Service License  10 Seph M. Ostn.	wwshi C.f.S./	)   F	ELLOWS		BEIN & NEW			HOME 1	?A.
Physiciar	,	23a. Part1. Enter the disease, or complice shock, or heart failure. List only on Immediate Cause (Final disease or condition	cations that caused the deat ne cause on each line.	h. Do not ente						Approximat Interval Bet Onset and	ween Death
/Medica Examine		resulting in death)	Due to (or as a conseq	/	١				1	muni	
- Zadinino		5 cuentially list conditions bif any, leading to immediate	Due to (or as a conseq	/-/ /	ma					monus	<u></u>
uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	Non-H	dkin	13 /	non	ra .			years	
\$8760, icate be executed physician and s the burial-transit	Exa	resulting in death) Last	Due to (or as a conseq	ju∍o ≃ of):	-	1			-		
58760, ficate be ex physician s the burial	dlcal		l								
Box 6 Box feath certification attending for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	3c. If yes, outcome of pregnation 1 □ Live birth 2 □ Feta	ıl death 3 □	Ectopic pregr			2	3d. Date of deliv	*	Year
P.O. that the deby the detached	hysl	9 Unknown	9□ Unknown								
cords, F w requires that been signed I should be det	b	Part II. Other significant conditions con Thabetes me		sulting in the ur	nderlying caus	e given in Part I.			se contribute to		death? Unknown
E 2 2 8	Completed						24a. Was auto perfe		death?	opsy findings ompletion of c	available ause of
Vital F sicien: Th s certificate lirector, pag	BeC	25. Was case referred to medical examiner?				26. Place o	of Death (Check only				
of Vita Physicien: r this certific real director,	2	1 ☐ Yes 2 📉 No		ER/Outpatien			sing Home 5 Res			fy)	
ling After	lon:	27. Manner of Death  1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe	how injury	occurred		
or A or A or A or A or A or A	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Specia	ome, farm, stre fy)	M eet, factory, of		28f. Location	Street and wn, State)	d Number or Rur	al Route Num	iber,
Hospite 14 hours Funerel	dical	29a. Certifier (Check only one)  Certifying Physical Examination	sician: To the best of my kno ner: On the basis of examina and manner stated.	owledge, death	occurred at t restigation, in	he time, date and my opinion, death	place, and due to the occurred at the time,	cause(s) a	and manner as : place, and due !	stated. to the cause(s	;)
To the within 2 To the complet	Med	29b. Signature and title of certifier			29c. Li	cense number		29d. Date	signed (Month,	Day, Year)	
->		· ////	trongs.			DZ593	33		4.6.0	5	
(10)		30. Name and address of person who co		11 23a) (Type.		LANE	EAST	on 1	MD.	21601	
S Regis	tate	31. Date filed (Month, Day, Year) APR 0 7 2	32. Regitrar's Signa	ature	A. m						

Thomas Cavanaugh

		1	For State of	Maryland / Dep	partment of ertificate of			iene	105	13591
		_	Decedent's Name (First, Middle, Last)				2. Date of Death	h Day	Year	3. Time of Death
	Physicia /Medic		JOSEPH FRANCIS CALLAHAN				MARCH	31	2005	5:30PM M
	Examin		4a. Facility Name (If not institution, give street and num	ber)		n, or Location of Death		4c. Coun	ty of Death	
			410 TRIPPE AVE.	Ann //n .um look hirthyda		STON ar If Under 24 Hrs.	8. Date of Birth		TALBO	lace (State or Foreign
	Funeral		5. Social Security Number 6. Sex 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	'. Age (In yrs. last birthda 82 Yrs.	Months Da		FEB 11	Year) 1923	Coun OH 3	try)
	Director	-	Usual Residence of Decedent				THD II.			
	yland		10a. State 10b. County	10c. City, Town or	Location				1	Od. Inside City Limits
	a-fs	ctor	MD TALBOT	EASTO	NN					XiX Yes 2 □ No
	or 28	Director	10e. Street and Number		10f. Zip Cod		11	0g. Citizen o	f What Coun	itry?
	ath w		410 TRIPPE AVE.		1	21601	posity Vos or No	14 B	USA ace · Americ	an Indian
	er de Items	Funerai	11. Marital Status  12. Was Decendanted For Armed For 1 Never Married X Married 1 XYes	dent Ever in U.S. 13	If Yes, specify C	of Hispanic Origin? (Suban, Mexican, Puerl	o Rican, etc.)		lack, White,	
35	hours after death with the Maryland turat', or Items 23a or 28a-f show at Examiner must be mailfied at	by F	3 Widowed 4 Divorced Year or Da	9	1 ☐ Yes X☐	No Specify:		Spec	eify: WI	HITE
215-0036	be filed within 72 hours after death with the Marylan dat Hygiene. Ida Hygiene. Ida chtar than "naturat", or Items 23a or 28a-f show arent. It e Marical Examiner mast be mailited at		15. Decedent's Education (Specify only highest grade completed)	16a. De	cedent's Usual Oc	cupation one during most of wor	kina	16b. Kind of	Business/Inc	dustry
2	within 72 ene. than "nai	Completed	Elementary/Secondary (0-12) College (1-	life	. DO NOT use re	tired)	9			
7	filed wi Hygien Sthar th ant, Ire	Con	12 5+		TEACH		ne (First, Middle, M			DUCATION
DUE.	ould be fil Mental H arkad otl atic avar	Be	17. Father's Name (First, Middle, Last)				ENCE BUC		arrio)	
Maryland	should be filed ind Mental Hygi markad othar umatic avant, I	٦ ک	AUSTIN R. CALLAHAN  19a. Informant's Name/Relationship (Type, Print)	19b. Ma	uiling Address (Str	eet and Number or Ru			m, State, Zip	Code)
<u>8</u>	s 1 and 2 should f Health and Men itam 27 Is marks othar traumatic		ELIZABETH CALLAHAN/WIFE	41	O TRIPPE	AVE., EAS	TON, MD	21601		
ē,	itam othal		20a. Method of Disposition		sposition (Name o rematory or other	f   place)	Date	20c. Locatio	n - City or To	own, State
Ë	Pages nent of int: If it iry or o		1 ☐ Burial 2 【Acremation 3 ☐ Removal from 5 `4 ☐ Donation 5 ☐ Other (Specify)	state	_	TION CTR.	4-2-2005	STEV	ENSVII	LLE, MD
altimore,	permit. Pages Department of Important: If it any injury or o		21. Signature of Funeral Service Licensee		22. Name and Ad	and the state of t			IEDAT I	HOME DA
<u> </u>	89588		Joseph 20, Ostrough C.	r. 5	200 S. H	ARRISON ST	EASTON.	MD 21	601	
I.			23a. Part1. Enter the disease, or complications that ca shock, or heart failure. List only one cause on ea	ich iine.				est,		Approximate Interval Between Onset and Death
	Pnysician		Immediate Cause (Final disease or condition resulting in death)	dino CARC	ENOMA	OF THE	LUNG		-	2 monTHs
	/Medical Examiner		Due to (	or as a consequence of):			0			
		F.		or as a consequence of):						
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events  c							
o	ate be executed hysician and the burial-transit			or as a consequence of):						
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	licai	d							
<u>ب</u> و	leath certifica attending ph I for use as th	/Med	IF FEMALE: 23c If was out	come of pregnancy				234	Date of delive	any.
Вох	attend for us	by Physician/M	in the past 12 months?	irth 2 Fetal death	3 □Ectopic pregn 5 □ Other (specif				Month	Day Year
o.	res that the de signed by the a be detached f	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown							
<u>α</u>	s that ned b e deta	y P	Part II. Other significant conditions contributing to de	eath but not resulting in th	e underlying cause	e given in Part I.	23e. Did to	bacco use co		he cause of death?
rds	w require been sig should b						1 □ Y	es 2□No	3 <b>⊉</b> Prob	pably 4 □Unknown
Records,	e law requ has been ye 2 shoul	Completed					24a. Was a autops	sy	prior to co	psy findings available mpletion of cause of
	The ate ha	Com					perform 1 Yes	med? 2 No	death? 1  Yes	2 No
Vital	Physician: r this certifica ral director, particularies	Be	25. Was case referred to medical examiner?			Othor	ath (Check only or			
of	hysi this c	2		npatient 2 EP/Outpa			lome 5 X Reside			(y)
	Jing F	ion	i ematural S investigation	of Injury h, Day Year) 28b. Tim- Injury	ry M	Injury at Work? 1 ☐ Yes 2 ☐ No	200. 5000.150 11	o to inquity ook		
Division	Attanding ir death. actor: After by the fune	ficat	3 Suicide 6 Could not be	of Injury - At home, farm,					mber or Rura	al Route Number,
$\leq$	at or A after Dira d in b	Certification;	4 Homicide determined buildi	ng, etc. (Specify)			City or Tow	n, State)		
	Hospital 4 hours s Funaral tely filled		29a. Certifier 1 ☐ Cartifying Physician: To the (Check only 2 ☐ Madical Examinar: On the b	best of my knowledge, d	eath occurred at the	ne time, date and place	e, and due to the curred at the time	ause(s) and	manner as s	tated. o the cause(s)
	To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	fedical	one) and man	per stated.		cense number			ned (Month,	
	To To con	Σ	29b. Signature and title of certifier	//	7	3/4//		4//	1/05	-
•			hashing / / B	no of death (line 222) The	DO Print)	1.106		///	103	
/	o+INA		30. Name and address of person who completed cause LUDWIG J. EGLSEDER, III			AVE. EASTO	MIN 21	601		
		ate	LUDWIG J. EGLSEDER, III 31. Date filed (MAPP 89) Year) 7005	egistrar's Signature	التلالاتتتان الم	AVE. PASIO	111 <u>C L</u>	UVI		
	Regist		V J 2003	and All A	Soul!					

			1 - For State Registrar	State of Maryla	and / Dep			ental Hygi	•	13592
	Physici	an	1. Decedent's Name (First, Middle, La	st)				2. Date of Death Month		3. Time of Death
	/Media		Gottrell	Carson				larch 3	1, 2005	5:54A M
	Examir	er	4a. Facility Name (If not institution, giv	·			or Location of Death		4c. County of Deat	h
	-		Prince Georges  5. Social Security Number 6.5		center rs. last birthday)		Verly If Under 24 Hrs.	8. Date of Birth	P.G.	holana (State or Foreign
	Funeral Director		,	M 2□F	91 Yrs.	Months Days	Hours Min.	Month, Day, 13	( GO	hplace (State or Foreign untry) GA
	ylanc		10a. State 10b. County	10c.	City, Town or Lo	ocation				10d. Inside City Limits
	e-f s	ctor	Md. P.G.		Upper	Marlbon	ro			M☐Yes 2☐No
	ier death with the Marylan Items 23e or 28e-f show Inclination all	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Co	untry?
	ath w		306 Fuller Aver			2077			Inited St	
	ltems	Funeral	11. Marital Status	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2X No	U.S. 13.	Was Decedent of F If Yes, specify Cub	lispanic Origin? (Spec an, Mexican, Puerto P	cify Yes or No- lican, etc.)	14. Race - Amer Black, White	
36	irs aft	by F	1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 ☒ No	Specify:		Specify:	- 1-
Š	d within 72 hours after death with the Maryland jiene. I'the maturel', or Items 23e or 28e-1 show I'the Medical Exarcase.	led	15. Decedent's E	ducation	16a. Dece	dent's Usual Occup	pation	10	BLa 6b. Kind of Business/I	
215	hin 7.	Completed	(Specify only highest gra Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give	kind of work done DO NOT use retire	during most of workin d)	g		•
21	77 E b 448	Con	3		Tex	ktile Wo	orker		Private	
nd	be filk tal Hy d oth d oth	Be (	17. Father's Name (First, Middle, Last,				18. Mother's Name		aiden Sumame)	
yla	should be ind Mental s marked o umatic eve	ဥ	John Carson				Minnie T			
Maryland 21215-0036	0, 50 00 3		19a. Informant's Name/Relationship (		19b. Maili 306	ng Address (Street Fuller	and Number or Rural Avenue	Route Number,	City or Town, State, Z	ip Code)
d)	of Health of Health item 27 i		Phyllis Widemo		Uppe	er Marlk Disition (Name of	oro, Mar	yland	20774 Oc. Location - City or 1	
Baltimore,	permit. Pages 1 Department of H Importent: If ite eny injury or ot		1 Burial 2 Cremation 3	Removal from State	cemetery, cre	matory or other pla	сө)	4	•	
들	it. Particular		'4 □ Donation 5 □ Other (Special 21. Signature of Funeral Service Lices		arolina	a Mem. I	Park 4/8/	05 C	oncord,	N.C.
Ba	Depariming Department of the partment of the p		Maning S	Asirisol-	1 30	210 Cil	zer Hill	iges &	Edwards : uitland,	F.H Md 20746
	Pnysician /Medical		23a. Port1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that caused the de one cause on each line.  a. Fatal Car Due to (or as a cons	eath. Do not en	er the mode of dyir	ng, such as cardiac or			Approximate Interval Between Onset and Death
	Examiner	,	Sequentially list conditions,	<sub>b.</sub> Coronary		y Diseas	se			
	sit sit	Examiner	cause. Enter Underlying	Due to (or as a cons					79	
	icate be executed physician and s the burial-transit	Kam	Cause (Disease or injury that initiated events resulting in death) Last	c. Heart Fai						
8760,	be exician buria	icai E		Due to (or as a cons	aquanca or,					
687	physis the	edica		_ d						V
.O. Box 6	it the death certificate be executed by the attending physician and tached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of preg 1 Live birth 2 Fe 4 Pregnant at time of 9 Unknown	etal death 3	Ectopic pregnancy Other (specify)	/		23d. Date of delin	very Day Year
Records, P.	es tha igned be de	by	Part II. Other significant conditions of	ontributing to death but not r	esulting in the u	nderlying cause giv	en in Part I.		cco use contribute to	the cause of death?
00	> 0	Completed		-				24a. Was an	24b Ware aut	opsy findings available
Re	<b>⊕</b>	dmo						autopsy performe	prior to co death?	ompletion of cause of
Vital	icien: Th certificate rector, pag	Ö	25. Was case referred to medical				26. Place of Death	1 Yes 2		2 <b>X</b> No
>	Physicien: r this certific ral director,	0 8	examiner? 1 ☐ Yes 2 ☐ XNo	Hospital: 1 Inpatient 2	ER/Outpatier	nt 3 DOA Oth	000		ce 6 ☐Other (Speci	rfv)
ion of	ding h. After fune	ation: T	27. Manner of Death 1	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	28c. Injur Wor		3d. Describe how		
Division	s after death	Certification:	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Injury - At building, etc. (Spe	home, farm, str cify)	eet, factory, office	28	Bf. Location (Stre City or Town,	et and Number or Rui State)	ral Route Number,
	To the Hospitel or At within 24 hours after of To the Funerel Direct completely filled in by	dical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of my k niner: On the basis of exam- and manner stated.	nowledge, deat nation and/or in	n occurred at the tir vestigation, in my o	me, date and place, ar pinion, death occurred	d due to the cau d at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)
	To the within To the Comple	Me	29b. Signature and title of confier	* 0000		29c. Licens			I. Date signed (Month,	
)			11/6/2	1 , , , ,		Doc	57039		4/1/05	
R	(6)		30. Name and address of person who	completed cause of death (It	ет 23а) (Туре,	Print)				-
			Dr. Babak Razi		nsbury	Rd., R	iverdale	, Md. 2	20737	
	Sta Registr	_	31. Date filed (Month, Day, Year)  APR 0 8 2005	32. Registrar's Sig	nature	B				

			Please	Type or Prin					9	
			For State	State of Ma	aryland / Depa	artment of I <i>rtificate of</i>		ental Hygi	ene nns	13503
			Registrar  1. Decedent's Name (First, Middle, L	nati	Ce	runcate of	Death	2. Date of Death	g. No.	3. Time of Death
	Physici	an	Eva Mae	Childs				Month March 3	Day Year	8:00P M
	/Medic		4a. Facility Name (If not institution, g			4b. City, Town,	or Location of Death	dar cir 5	4c. County of Dea	
4	Examin	er	Fox Chase Reha		sing Cent		lver Spri	ing	Montgor	
	Funeral				e (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Bi	rthplace (State or Foreign
	Director		577-44-8891	1 ☐ M 2X F	70 Yrs.			July 30	, 1934	Wash.,DC
	land		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	ocation			<del></del>	10d. Inside City Limits
	the Marylan 28e-f show notified at	tor	Md. P.G	•	Hyatts	sville				1 ☑ Yes 2 ☐ No
	or 28e	Funeral Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What C	country?
	23a c	ral	6050 Sargeant	Road		20782			nited St	ates
	tems	nue	11. Marital Status	12. Was Decedent Armed Forces?		Was Decedent of I If Yes, specify Cub	Hispanic Origin? (Spe pan, Mexican, Puerto I	cify Yes or No- Rican, etc.)	14. Race - Am Black, Wh	
36	rs afte	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Wivorced	1 ☐ Yes 2 🔯 i If Yes, Give Year or Dates:	10	1 ☐ Yes 2 🔽 No	Specify:		Specify:	a ale
9	2 hou	ted	15. Decedent's	Education	16a. Dece	dent's Usual Occu	pation	1	6b. Kind of Busines	_ack s/Industry
21215-0036	within 72 hours after death with the Maryland ene. than "naturel", or Items 23a or 28e-f show the Medical Examinet must be notified at	Completed	(Specify only highest of Elementary/Secondary (0-12)	College (1-4or 5	life.	DO NOT use retire	during most of workingd)			
	led wi ygien har th it, the		12		Post	al Clei				st Office
and	Ibe fi	Be	17. Father's Name (First, Middle, La. Edward Harris	SI)			18. Mother's Name Sarah Wh		laiden Surname)	
Maryland	12 should be filed within n and Mental Hygiene. 7 is marked othar than " iraumatic evant, the Med	2	19a. Informant's Name/Relationship	(Type, Print)	19b. Maili	na Address (Stree			City or Town. State.	Zip Code)
<b>≅</b>	s 1 and 2 should be filed within 72 hours after death with the Maryla of Health and Mental Hygiene. Itam 27 ia marked othar than "naturel", or Items 23a or 28e-f sho other traumatic event, the Medical Expension and be notified at		Darlene People		er 8809	Temple	t and Number or Rura Hill Ro	20735	,	,
altimore,	s 1 a of Hee itam othe		20a. Method of Disposition		20b. Place of Dispo	osition (Name of matory or other pla	. D		0c. Location - City o	r Town, State
Ē	Page nent c		1 ☐ Burial 2 🖾 Cremation 3  1 ☐ Donation 5 ☐ Other (Spec		1	-	atory 4-8-	-05	River	dale, Md.
alt	permit. Pages 1 and 2 Department of Health a Important: If itam 27 is eny injury or other tra ance.		21. Signature of Funeral Service Lic	ensee	/ )	2. Name and Addr	210		Edwards	
8	<u>v</u> □ = ⊕ α	_	- Januce 9	divara			ver Hill			Md.20746
			23a. Part 1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final	ly one cause on each li	i the death. Do not en le.	ter the mode of dy	ing, such as cardiac o	r respiratory arre	SI,	Approximate Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death)		atic Cole a consequence of):	on Canc	er			-
	Examiner				a consequence or).					
L		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as	a consequence of):					
	acuted and transi	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	с						
760,	The law requires that the death certificate be executed that been signed by the attending physician and ten has been signed by the attending physician and page 2 should be detached for use as the buriat-transit	alEx	resorting in death, cast	Due to (or as	a consequence of):					
687	physics the t			d						
Box (	leath certificate attending phys I for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome					23d. Date of de	elivery
	w requires that the death cer been signed by the attendir should be detached for use	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1∐Live birth 4∏Pregnant at 9∏Unknown		⊒Ectopic pregnand ⊒ Other (s <i>pecify</i> ) _	;y		Month	Day Year
P.O.	at the	hys	9 ☐ Unknown							
	res th signed be de	by	Part II. Other significent conditions	contributing to death b	ut not resulting in the L	inderlying cause gi	ven in Part I.			to the cause of death?  Probably 4 Unknown
orc	requi	Completed					-			
3ec	has t	mpi						24a. Was an autopsy perform	24b. Were a prior to death?	utopsy findings available completion of cause of
of Vital Records,	n: Th fficate or, pag		25. Was case referred to medical				26. Place of Death	perform 1 Yes 2		s 2X No
5	Phyaician: this certific	To Be	examiner?	Hospital:	ent 2 ☐ ER/Outpatie	nt 3□ DOA Ot	han		nce 6 Other (Sp	ecify)
O	g Phy ler thi	T:u	27. Manner of Death 1   Manual 5 □ Pending	28a. Date of Inju (Month, Da				28d. Describe hov		
sior	Attanding r death. actor: After y the fune	atic	2 Accident investigat	ion	, , , , , , , , , , , , , , , , , , , ,		Yes 2□No			
Division	or Att	rtific	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		ury - At home, farm, st c. <i>(Specify)</i>	reet, factory, office	2	28f. Location (Str. City or Town,		Rural Route Number,
	Hoapital ( 4 hours al Funeral D	Ce	29a, Certifier 1 X Certifying	Physicien: To the best	of my knowledge, does	th accuract at the t	ima data and place a	and due to the co	una(a) and manner	a stated
	24 ho a Fun etely	Medical Certification:	(Check only 2 Medical Ex	aminer: On the basis o and manner st	f examination and/or in	ivestigation, in my	opinion, death occurre	ed at the time, da	te and place, and du	e to the cause(s)
	To the Hoapital or Attanding Phyalcian: The law within 24 hours after death. To the Funeral Diractor: After this certificate has completely filled in by the funeral director, page 2	Me	29b. Signature and title of certifier	2	A	E .	se number	-	d. Date signed (Mor	ith, Day, Year)
			1	1/2	- 1	1)0	05859	17	04-01	0-05
X	(5)		30. Name and address of person wh							20910
✓ [			Dr. Shahryar 31. Date filed (Month, Day, Year)		orla Cianatura		ve., Sui	te #404	B,Silve	r Spring,Mo
	Sta	ite	APR OR 26	ns Linegisti	ai a digitature	100				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State
Registrar/MEND#2per/MD4/5/05, EMW, McCo Certificate of Death Reg. No. 2. Date of DeathMarch 27 1. Decedent's Name (First, Middle, Last) 2005 3. Time of Death aradire 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 21204 ManorCare Kuxton 700 N.Charles mn Baltimore Bultimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Days 1 ☐ M 2 ☐ F 121-01-2063 Usual Residence of Decedent 98 December 12, 1906 Holguin, Cuba 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7001 N. Charles Street 21204 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 □XYes 2□ No Specify: Cuban 3√Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Saleswoman Garfinkels 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Miguel Tenorio Presentacion Tevia 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Albert C. Camacho ( Son) 7001 01d House Road, McLean, VA 22101 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
1 ☐ Donation 5 ☐ Other (Specify) Gate Of Heavemetery 4/1/05 Silver Spring, MD 22. Name and Address of Facility Murphy Falls Church Funeral Home 21. Signature of Funeral Service Licensee march 1102 W. Broad St., Falls Church, VA 22046 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Atheroscleritic Carchiovascular Divease Due to (or as a consequence of) Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy 4☐Pregnant at time of death Month Day Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 22 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No 24a. Was an autopsy performed' 1 Tes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner' 1 Yes 25 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA

**Physician** /Medical **Examiner** Examiner

burial-transit

attending physician and for use as the burial-tran

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this

After

Director:

within 24 hours a To the Funeral C

Physician/Medical

þ

Completed

Be

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Certification:

Medical

The law requires that the death certificate be executed

To the Hospital or Attending Physician:

death.

Division of Vital Records, P.O. Box 68760

**Physician** 

/Medical

Examiner

10a, State

Directo

Completed by Funeral

Be

2

**Funeral** 

**Director** 

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show ampoints. If Item 27 is marked other than "natural", or Items 23a or 28a-f show amply injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

death with the Maryland

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No

Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Other: AND Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

Neck Rd

27. Manner of Death 1 Matural 2 Accident 3 Suicide

4 Homicide

29a. Certifier

5 Pending investigation 6 Could not be determined

28a. Date of Injury (Month, Day Year) Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Location (Street and Number or Rural Route Number, City or Town, State)

t⊠ Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier

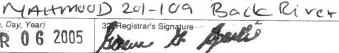
29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

31. Date filed (Month, Day, Year) 06



		1 - For State Registrar	State of Marylan	-	artment of rtificate of			giene Reg. No 200	5 13595
Physici: /Medic Examin	cal	1. Decedent's Name (First, Middle, Last)  Maraile Hn No.  4a. Facility Name (I) not institution, give s			4b. City, Town,	or Location of	2. Date of De Month	Day Yea	1505 PM
Funeral Director	lei	Anne Arundel Medic 5. Social Security Number 6. Sex	al Center	last birthday) Yrs.	Anr If Under 1 Year Months Days		4 Hrs. 8. Date of Bir Min. (Month Day May 29		Arundel Birthplace (State or Foreign Country) Mary land
ne Maryland 8e-f show	ector	10a. State 10b. County  Maryland Anne Aru		y, Town or Lo	Ann	napolis			10d. Inside City Limits 1XXYes 2 □ No
with th	Dir	10e. Street and Number 176 Woods Drive			10f. Zip Code	1403		10g. Citizen of What United St	
n 72 hours after death with the Maryland "natural", or Items 23e or 28e-f show odeal Examinan must be mailfied a	by Funeral Director		2. Was Decedent Ever in U Armed Forces? 1 □ Yes 2 → No If Yes, Give A Year or Dates:	- 1	Was Decedent of If Yes, specify Cul		n? (Specify Yes or No Puerto Rican, etc.)		merican Indian,
a within 72 ho giene. or than "natur tre Medical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or 5+)	(Give	dent's Usual Occu kind of work done DO NOT use retin	e during most ( ed)		16b. Kind of Busine	ss/Industry al Institute
ntal Hygi od other event, I	To Be Co	17. Father's Name (First, Middle, Last)  Gordon Crandell Sh	erbert	113111		18. Mother	s Name (First, Middle	, Maiden Sumame)	
aalth a n 27 ls er trei		19a. Informant's Name/Relationship (Type Richard Cordle / H) 20a. Method of Disposition 1 \( \begin{array}{c c} \begin{array}{c c} 1 & \b	usband 20b. F	176 Place of Dispo	J	Drive	or Rural Route Numb Annapolis Date	er, City or Town, State , Maryland 20c. Location - City	1 21403
Department of He Importent: If item any injury or oth once.		* 4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Ligense		22	2. Name and Addr	ess of Facility	John M.	Taylor Fur	neral Home, I is, MD 21401
nysician Medical		23a. Part1. Enter the sease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	cations that caused the deat e cause on each line.  Due to (or as a conseq	Puln	er the mode of dy			rrest,	Approximate Interval Between Onset and Death
ohysician and the burial-transit	i Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (pisease or injury that initiated events resulting in death) Last	Due to (or as a conseq						
attending for use as	hysician/Medicai	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 15 No 9 □ Unknown	3c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	Ideath 3□	Ectopic pregnand	су		23d. Date of o	delivery Day Year
been signed by the should be detached	by P	Part II. Other significant conditions con	tributing to death but not res	ulting in the u	nderlying cause g	iven in Part 1.	23e. Did t	A .	to the cause of death?  Probably 4 □Unknown
ate has page 2	Completed						24a. Was auto perfo	psy prior to prmed? death	autopsy findings available completion of cause of ? es 2 \square No
n. After this certificate funeral director, pag	tion: To Be	27. Manner of Death  1 Natural 5 Pending	ospital: 1 Inpatient 2  28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time of Injury	f 28c. Inju	ther: 4 🗆 Nurs	28d. Describe	one) dence 6  Other (Since the control of the contr	pecify)
within 24 hours after death. To the Funerel Director: After the completely filled in by the funera	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, str y)				Street and Number or wn, State)	Rural Route Number,
in 24 hou. the Funer pletely fill	edicai	(Check only 2 Medical Examinate)	sician: To the best of my kno ner: On the basis of examina and manner stated.		vestigation, in my	opinion, death		date and place, and d	lue to the cause(s)
with:	×	30. Name and address of person who co	eral Bech, tup		29c. Licer	u6052		29d. Date signed (Mo	onth, Day, Year)
Sta	ate	30. Name and address of person who co	mpleted cause of death (Iten 2001  Registrar's Signa	ture	Proporkwon	ano	napolis, Mi	>	

		1	State of Maryland / Dep	artment of Health and M <i>rtificate of Death</i>	ental Hygier Reg. 1	lim W W W	13596
I	Physicia	an	1. Decedent's Name (First, Middle, Last) Herman Percy Chew		2. Date of Death Month I	Day Year	3. Time of Death 12:15P M
	/Medic Examin		4a. Facility Name (If not institution, give street and number) 6230 9th Street	4b. City, Town, or Location of Death Chesapeake Bea		4c. County of Death Calv	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 18-34-5327 X M 2 F 68 Yrs.	If Under 1 Year   If Under 24 Hrs.     Months   Days   Hours   Min.	8. Date of Birth (Month, Day, Yea Sept. 1,		place (State or Foreign ntry) vland
	P		Usual Residence of Decedent				
	arylar show		10a. State 10b. County 10c. City, Town or Lary 1 and Calvert Che	esapeake Beach			10d. Inside City Limits 1 ☐ Yes 2 🗓 No
	th the M or 28a-f e notifie	Directo	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Cou	
	ath wi	rail	6230 9th Street	20732	at. Vac as Na	USA 14. Race - Ameri	oon Indian
39	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if fram 27 is marked other than "natural", or Itams 23a or 28a-f show important: if fram 27 is marked other than "natural", or Itams 23a or 28a-f show any injury or other traumatic event, Itam Moules Examilited at any injury or other traumatic event, Itam Moules Examilited at any injury or other traumatic event, Itam Moules Examilited at any injury or other traumatic event, Itam Moules Examilited at any injury or other traumatic event, Itam Moules Examilited at any injury or other traumatic event, Itam Moules Examilited at any injury or other traumatic event, Itam Moules Examilited at any injury or other traumatic event, Itam Moules Examilited at any injury or other traumatic event, Itam Moules Examilited at any injury or other traumatic event, Itam Moules Examilited at any injury or other traumatic event, Itam Moules Examilited at any injury or other traumatic event, Itam Moules Examilited at any injury or other traumatic event, Itam Moules Examilited at any injury or other traumatic event, Itam Moules Examilited at any injury or other traumatic event, Itam Moules Examilited at any injury or other traumatic events.	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 ☑ No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto I  ☐ Yes 2 No Specify:	icity Yes or No- Rican, etc.)	Black, White,	etc.
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121	vithin ne. han "	mple	Flementary/Secondary (0-12) College (1-40r.5+)	DO NOT use retired) Cicklayer		Constru	ction
р О	filed v Hygie other t		17. Father's Name (First, Middle, Last)		(First, Middle, Maid		
Maryland 21215-0036	ould be Mental Parkad c	To Be	Percy Chew	Gladys		Jones	- O- (-)
, Mar	and 2 sh alth and 27 is m ar traum		Odella Chew/Wife P.O	ing Address (Street and Number or Rura Box 663 Chesap			
Baltimore,	Pages 1 and nent of He Int: If Itam		1A Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	d Cemetery Apr.7	,2005	Location - City or T Huntingt	own, MD
Balti	permit. Departn Imports any inju		21. Signature of Funeral Service Licensee	2. Name and Address of Facility Sew 1451 Dares Beach	ell Fund Rd. Pr	eral Hom ince Fre	ed.,MD2067
	Physician /Medical		23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):	nter the mode of dying, such as cardiac of Static Cavair			Approximate Interval Between Onset and Death 4 NVS 2 LINES
в	Examiner						
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events				
8760,	rate be executed obysician and the burial-transit	dicai Exa	resulting in death) Last  Due to (or as a consequence of):				
68	tificati ig phy as the	ledi					
O. Box	the death certificate be executed y the attending physician and iched for use as the burial-transit	Physician/Me		□Ectopic pregnancy □ Other (specify)		23d. Date of deliv Month	ery Day Year
ds, P.O.	es that gned b	2	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobaco	co use contribute to to 2 on 3 □ Pro	
Records	has by	Completed			24a. Was an autopsy performed	prior to co death?	opsy findings available ompletion of cause of
Vital	ician: Th certificate rector, pag	a l	25. Was case referred to medical	26. Place of Death		No 1 ☐ Yes	2   NO
ί	S S	To B	examiner? 1   Yes   2   Yo   Hospital: 1   Inpatient   2   ER/Outpate	ent 3 DOA Other: 4 Nursing Hor	me 5 Hesidence	6 □Other (Speci	fy)
n of	ng Ph Iter th		27. Manner of Death 1 Natural 5 ☐ Pending 28a. Date of Injury (Month, Day Year) 28b. Time Injury	Work?	28d. Describe how in	njury occurred	
Division	al or Attanding P after death. I Diractor: After t d in by the funera	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	M 1 ☐ Yes 2 ☐ No	28f. Location (Street City or Town, St		al Route Number,
Ö	Hospital or A 14 hours after Funaral Dirac tely filled in by		29a. Certifier 1 Certifying Physician: To the best of my knowledge, dea	oth occurred at the time, date and place			stated
	To the Hospital or At within 24 hours after of To tha Funaral Dirac completely filled in by	edical	(Check only one)  2 Medical Examiner: On the basis of examination and/or and manner stated.	nvestigation, in my opinion, death occurr	ed at the time, date :	and place, and due t	to the cause(s)
	To t To t	M	29b. Signature and title of Certifier  7. Flouis UniO	29c. License number D 19838	<sup>29d.</sup>	Date signed (Month,	Day, Year)
_	10		29b. Signature and title of certifier  Teloculos UniO  30 Name and address of erson who completed cause of death (Item 23a) (Type SCIO Williams Completed)  31. Date filed (Month, Day Year)  APR 0 4 2005	Bestgate 1	Rd. A	nuapolis	, led.
**	Sta Regist		31. Date filed (Month, Day Year) APR 0 4 2005   Services &	Sperke			

State of Maryland / Department of Health and Mental Hygiene [] [] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Day Month Year **Physician** Apri 10:45 AM Dollana 6 2005 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 ☐ M 2**K** F Yrs. New York 577-42-5334 Director 100 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d, Inside City Limits item 27 la marked other than "natural", or Items 23a or 28a-f shov other traumatic event. It is Nedical Examinar must be notified at 1♥ Yes 2□No Directo MD Prince George's 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code USA 20783 3210 Powder Mill Road 72 hours after death by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 ☑ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Importent: If item 27 I a marked other than "nat any injury or other traumatic event, I as Medica once. (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Engla Oyer Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2952 Gracefield Road, Silver Spring, Maryland 20904 Maria E. Miles, Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 D€remation 3 □Removal from State 4/11/2005 Brentwood, Maryland ¹ 4 □ Donation / 5 □ Other (Specify) Fort Lincoln Cemetery 22. Name and Address of Facility Gasch's Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, Maryland an complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death 23a. Part I. Effer shock, or he heart failure. fmmediate Cause (Final oxaestive Heart Failure Physician disease or condition resulting in death) /Medical Examiner Atrial fibrilla Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lissate Triply) that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Accident 1 Yes 2 No 3 Probably 4 ☐Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 X No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certified completely filled in by the funeral director; 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 📉 No 10 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 06053337 2001 30. Name and address of person who completed cause of death (ftem 23a) (Type, Print) 10801 Lockwood Drive, Silver Spring, Maryland Dorothy Seay, . Registrar's Signature 31. Date filed (Month, Day, Year) State APR 0 8 2005

DHMH 17 Rev 1/2001

Registrar

			State of Maryland / Department of Health and Mo  1 - State Registrar  Certificate of Death		211115	13598
			Trogradus.	2. Date of Death	g. No. U	3. Time of Death
	Physicia		James Arthur Dahl	Month April 5	Day Year . 2005	5:30 a M
	/Medic Examin		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death		4c. County of Dea	
ı	LAGITITI		Montgomery Hospice-Casey House Rockville		Mo	ontgomery
	Funeral		Manufac Davis House Min	8. Date of Birth (Month, Day,	Year) 9. Bir	thplace (State or Foreign
D.	Director		534-18-7156 1⊠ M 2□ F 86 Yrs. Months Days Hours Mill.	Nov. 26	, 1918 Wa	shington
	pu ≱		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	Maryla sho	5	Maryland Montgomery Silver Spring			1 ☐ Yes 2 ☐XNo
	28a-1	Director	10e. Street and Number 10f. Zip Code	10	g. Citizen of What Co	ountry?
	with be or		15320 Pine Orchard Drive, #3G 20906		USA	,
	ns 23	era	11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Spec	cify Yes or No-	14. Race - Ame	erican Indian,
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "netural; or Items 23e or 28e-1 show any injury or other traumatic event, the Medical Examinating must be notified at once.	by Funerai	1 □ Never Married 2 Married   Armed Forces? 1943-46   If Yes, specify Cuban, Mexican, Puerto F	Rican, etc.)	Black, White Specify: W	
Ö	hour tural	q pa	3 ☐ Widowed 4 ☐ Divorced Year or Dates:  15. Decedent's Education   16a. Decedent's Usual Occupation		6b. Kind of Business	/Industry
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72	with jiene. r thai	mo	Elementary/Secondary (0-12)  College (1-4or 5+)  General Manager		Lumber Con	npany
פַ	othe vent,	Be C	17. Father's Name (First, Middle, Last)  18. Mother's Name		aiden Sumame)	
<u>la</u>	Menta	ToE	James Dahl Lotti	e Brown		
Maryland 21215-0036	2 sho and Is mu		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural)			20000
<u>~</u>	l and fealth im 27 her ti		Catherine B. Dahl/ Wife 15320 Pine Orchard Dri		, Silver S Oc. Location - City or	
Baltimore,	A Parity		1 🗷 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) April		uc. Location - City of	Town, State
≣	it. Pa rtmer rtent njury		'4 □ Donation 5 □ Other (Specify)			ng,Maryland
Ba	perm Depa Impo any i		21. Signature of unetal Service Licenset  22. Name and Address of Facility Francis J. Collins 500 University Blvc	Funeral l, W, Si	Home Inc lver Spri	ng, MD20901
			23a. Part1. Either the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line.	respiratory arre	st,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or conditiona_ Advanced Esophageal Carcinoma			Onset and Death
	/Medical Examiner		resulting in death)  Due to (or as a consequence of):			
Ь		-	Sequentially list conditions, if any leading to immediate Due to (or as a consequence of):			
	petr I Insit	min	Cause (Disease or injury			
Ć.	exection and ial-tra	Examiner	that initiated events c. Pue to (or as a consequence of):			
8760,	death certificate be executed e attending physician and of for use as the burial-transit	dicai	d			
9	rtifica ng ph	Med	IF FEMALE:		-	
Вох	eath certifii attending p	an/I	23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy 1		23d. Date of de Month	livery Day Year
o.	res that the death signed by the atter I be detached for t	by Physician/Med	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown 5 ☐ Other (specify)			
Δ.	that the sed by detac	Ph)	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did toba	acco use contribute to	the cause of death?
rds,				1 ☐ Yes	3 2 □ No 3 □ P	obably 4 \(\sum_\)Unknown
Vital Record	law requas been 2 should	Completed		24a. Was an autopsy	24b. Were a	utopsy findings available completion of cause of
œ _	The ate has page	Com		perform	ed? death?	2 □ No
/ita	cian: artific actor,	Be (	25. Was case referred to medical examiner?			
of	Physician: rthis certific ral director,	မ	1 ☐ Yes 2 🛣 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Hom			cify) Hospice
	ling F	ion	1 X Natural 5 ☐ Pending (Month, Day Year) Injury Work?	ad. Describe nov	v injury occurred	
Division	Attending ir death. ector: After by the fune	icat	3 Suicide 6 Could not be	8f. Location (Str.	eet and Number or R	ural Route Number.
<u>≥</u>	tal or A s after at Dire ed in b	Certification:	4 Homicide determined determined building, etc. (Specify)	City or Town,	State)	
	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edicai	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, a construction of my knowledge, death occurred at the time, date and place, a construction one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, a construction one)	nd due to the ca d at the time, da	use(s) and manner at te and place, and due	s stated. to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title or centrifier 29c. License number	29	d. Date signed (Moni	h, Day, Year)
)	15		MARICA D41218		4/5/0	25
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Charles Harrison, M.D. 6001 Muncaste Mill Road, Rocky	ville, M	D 20855	
	Sta Registi		31. Date filed (Month, Day, Year)  APR 0 6 2005  34 Registrar's Signature			

			1 - For State of N		epartment of F Certificate of			ene () () 5	13599
	Physici		1. Decedent's Name (First, Middle, Last) Franklin Toby Donovan				2. Date of Death Month	DayYear	3. Time of Death
	/Medio Examir		4a. Facility Name (If not institution, give street and number PANNSULA REGIONA MEDICAL	Conta	4b. City, Town, o	r Location of Death		4c. County of Death	1.
	Funeral Director		5. Social Security Number 6. Sex 1. M 2 F 7. A 1. M 2 F 9. Sex	ge (In yrs. last birthd 66 Yrs	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, ) Dec. 22,	Year) 1938 Mary	place (State or Foreign intry) 'Land
F	death with the Maryland ms 23e or 28a-f show in ust be notified at	tor	10a. State 10b. County Maryland Wicomico	10c. City, Town o	r Location				10d. Inside City Limits 1 ☐ Yes 2 🏋 No
Sh	with the e or 284 Lbe not	Direc	10e. Street and Number 706 Corporation Road		10f. Zip Code 2186	. 1	100	g. Citizen of What Cou	ntry?
00001AN	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other then "netural", or Items 23e or 28a-f show any injury or other traumatic event. The Medical Examinet must be notified at ance.	Funeral Director	11. Marital Status  1 ☑ Was Deceden Armed Forces  1 ☑ Never Married 2 ☐ Married  1 ☐ Yes, Give	t Ever in U.S. 1	13. Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Span, Mexican, Puerto	ecify Yes or No- Rican, etc.)	USA 14. Race - Ameri Black, White	
25- ? 215-0036	"netural",	leted by	3 ☐ Widowed 4 ☐ Divorced If 1 ses, Give year or Dates  15. Decedent's Education (Specify only highest grade completed)	16a. De	ecedent's Usual Occup ive kind of work done fe. DO NOT use retired	ation	ing 16	Specify: W	hite
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FRANKLIN 900-	uld be fil Mental H arked otl	To Be	17. Father's Name (First, Middle, Last) Alexander Donovan				e (First, Middle, Ma Mae Johns		
	nd 2 sho lith and 27 is ma r trauma		19a. Informant's Name/Relationship (Type, Print) Fulton E. Lowe/Friend		ailing Address <i>(Str</i> eet D Nanticoke				
Baltimore,	ages 1 a nt of Hea t: If item / or othe		20a. Method of Disposition  1 □ Burial 2 □ Cremation 3 □ Removal from State  4 □ Donation 5 □ Other (Specify)	20b. Place of Dicemetery, of	isposition (Name of crematory or other place	(6:	Date 20	Oc. Location - City or T	own, State
Baltir	permit. P Departme Importan any injur		21. Signature of Funeral Serving Lines see		22 Name and Addre	no of English	_	elmar, Del Box 3171 alisbury, 1	
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	/Medical Examiner			s a consequence of):	eliac Cr ntriwlar	- Fibril	lation		
8760,	rate be executed obysician and the burial-transit	dical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events  c.	s a consequence of): s a consequence of):					
P.O. Box 68	The law requires that the death certificate be ite has been signed by the attending physicis bage 2 should be detached for use as the bur	Physician/Med		2 Fetal death	3 □Ectopic pregnancy 5 □ Other (specify)			23d. Date of delive	ery Day Year
rds, P	quires that n signed t uld be det	by	Part II. Other significant conditions contributing to death			en in Part I.		cco use contribute to to	he cause of death? pably 4 \( \square\) Unknown
Division of Vital Records,	iician: The law requir certificate has been si rector, page 2 should	Completed	C-Spire Fract Sub arachnoid	demorray	2		24a. Was an autopsy performe	prior to co death?	ppsy findings available mpletion of cause of 2 No
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sion	Attanding death. ctor: Afte y the fune	Certification;	1 Natural 5 Pending 2 Accident investigation (Month of	5 192	World 1	(? Yes 2 ♥No	Fall of	t bike	
Dívi	To the Hospital or Attanding within 24 hours after death. To the Funerat Director: Afte completely filled in by the fune		4 Homicide determined 286. Place of the building, e	njury - At home, farm, tc. (Specify)		1	Po Boo 74	4 Shurpton	am, mo
	the Hosp in 24 hou the Fune pletely fi	edical	29a. Certifier (Check only one)  1 Certifying Physician: To the best 2 Medical Examiner: On the basis and manner s	of examination and/or	eath occurred at the tin r investigation, in my o	ne, date and place, a pinion, death occurre	and due to the caused at the time, date	se(s) and manner as s a and place, and due to	ated. the cause(s)
	To I To I	Σ	29b. Signature and Itle of certifier			497	4	Date signed (Month,	
_			30. Name and address of person who completed cause of Christopher Soyder 11	death (Item 23a) (Typ	pe, Print)	Solich	16.1	0 - 2/02	/
	Sta Registr		31. Date filed (Mohth, Day Year) 0 8 2005 <sup>2</sup> . Regis	var's Signature	Source	_W1301)	19,111	~ ~1001	

			For State Registrar	State of Ma	ryland /	•	rtment of He		Mental Hy	2000	12600
			Registrar  1. Decedent's Name (First, Middle, Last)				imouto of B	- Catri	2. Date of De		3. Time of Death
	Physicia		Dorot	hy Virgin	ia Est	es			Month	Day Year	- 5:20 AM
	/Medic Examin		4a. Facility Name (If not institution, give	street and number)			4b. City, Town, or L	ocation of Dea	ith	4c. County of Dea	
			Citizens Nu	13/19	Hom	Q	Havre	del	Sme	Hart	ord
	Funeral		5. Social Security Number 6. Sec	M 2 XF	(In yrs. last b		If Under 1 Year Months Days	If Under 24 Hr Hours Mir	s. 8. Date of Bi	th 9. Bir ay, Year) 9. Bir 6, 1912	thplace (State or Foreign
	Director	-	212-12-1700 1L Usual Residence of Decedent	7.10	92	Yrs.			Sept.	6, 1912	Maryland
	land	1	10a. State 10b. County		10c. City, Tox	wn or Lo	cation				10d, Inside City Limits
	Marylan -f ehow Bad ut	ţō	Maryland Harf	ord			Havre o	de Grac	е		1 ⊠Yes 2 □ No
	h the r 28e	irec	10e. Street and Number				10f. Zip Code			10g. Citizen of What C	ountry?
	death with the Maryland ms 23e or 28e-f ehow rmust be notified ut	Funerai Director	515 Warren Street					21078		U.S.	
	rdea	ner	The state of the s	12. Was Decedent 8 Armed Forces?		13. V	Vas Decedent of His Yes, specify Cuban	panic Origin? ( , Mexican, Pue	Specify Yes or Norto Rican, etc.)	14. Race - Ame Black, Whi	
36	s afte	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☒ N If Yes, Give Year or Dates:	lo	1	☐ Yes 2⊠ No	Specify:		Specify:	White
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21,	ad witt	Completed	Twelve Years				Homemake				Residence
Maryland 21215-0036	be file tal Hy d oth event	Be	17. Father's Name (First, Middle, Last)	T. Damed				18. Mother's Na		, <i>Maiden Sumame)</i> nne Lowe	
<u>₹</u>	Men Men Marke Marke	Jo	Benjamin (Tablication (T		10	No Mailin	- Address (Street or	ad Number or I		er, City or Town, State,	Zin Code)
Mar	32 sh th and 7 ie n treun		19a. Informant's Name/Relationship (Ty Ruth E. Dever (I	Daughter)						lle, Maryla	
Γ	1 and Healt Hem 2		20a. Method of Disposition		20b. Place	of Dispos	sition (Name of	-	Date	20c. Location - City or	
JO II	ages ant of tt: If it		1 ☑ Burial 2 ☐ Cremation 3 ☐ F  '4 ☐ Donation 5 ☐ Other (Specify)				natory`or other place, porial Garde	1	/13/05	Bel Air, M	arvland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatht and Mental Hygiene. Importent: If item 27 ie marked other then "neturel", or Items 23e or 28e-1 ehow any injury or other treumatic event, I'm Medical Examiner must be notified at once.		21. Signarure of Funeral Service Licens			22	. Name and Address	of Facility	-		
ä	Dep Imp		Thomas, he t	THENDS	W. Gr.		ee A. Patt erryville,			neral Home, 03-0766	P.A.
			23a. Part1. Enter the disease, or compl shock, or heart failure. List only or	ications that caused ne ceuse on each lir	the death. Do						Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Berzon	10- J	20m	enté				Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a consequence	e of):					70010
190	Examine	L	Sequentially list conditions,	Due to (or as	a consequence	e of\·					/
	ed sit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Unisease or injury	Due to (or as	a consequence	e orj.					
	be executed sician and burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as	a consequence	e of):					
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burral-transit	icai		d							
68	tificate ig physias the		101111111111111111111111111111111111111	- 1					-		
ך	leath certifica attending ph i for use as th	an/N	23b. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth		th 3□	Ectopic pregnancy			23d. Date of de Month	livery Day Year
I	e deal he att	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☒ No	4☐Pregnant at 9☐Unknown	time of death	5[	Other (specify)			Mondi	Day 100.
P.O.	nat the d by t letach		9 ☐ Unknown  Part II. Other significant conditions co	ntributing to death b	ut not resulting	in the ur	nderlying cause giver	n in Part I.	23e. Did	tobacco use contribute t	o the cause of death?
Z, S,	uires that the de signed by the a ld be detached f	by	Tarille States	+0 +h	VIIIA	, 111 (110 11	idonying oddoc givor		1 🗆	Yes 2 →No 3 □ P	robably 4 Unknown
Scord ecord	w requir been si should	Completed	Tallar		1 / V &				24a. Wa:	s an 24b. Were a	utopsy findings available
Rec .	<b>sicien:</b> The law certificate has t irector, page 2 s	mp							auto perf	psy prior to death?	utopsy findings available completion of cause of
Vital (	in: The ificate or, pa	င်	25. Was case referred to medical					26. Place of D	1 ☐ Yes eath (Check only		s 217 Mo
	ysicie s cert direct	0 8	avaminar?	Hospital: 1 ☐ Inpatie	nt 2 ER/C	Outpatien	Other		THE RESERVE OF THE PARTY OF THE	idence 6 ☐Other (Spe	ecify)
100	g Phy ter thi	n: T	27. Manner of Death 1 ⊠Natural 5 ⊡ Pending	28a. Date of Inju (Month, Da	ry 28b	. Time of	28c. Injury Work	at ?	28d. Describe	how injury occurred	
7 5	endin sath. or: Af he fur	atlo	2 Accident investigation					es 2 □ No			,
Division	or Att	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injuding, et	ury - At home, c. <i>(Specify)</i>	farm, str	eet, factory, office			(Street and Number or F lwn, State)	ural Route Number,
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certifies completely filled in by the funeral director, I		29a. Certifier 12 Certifying Phy	reician: To the hest	of my knowled	ne death	occurred at the time	a date and nia	ce, and due to the	cause(s) and manner a	s stated
	Hos 24 ho Fun	edical	(Check only 2 Medical Examone)	iner: On the basis of and manner sta	examination a	and/or in	vestigation, in my opi	inion, death oc	curred at the time	, date and place, and du	e to the cause(s)
_	o the	Me	29b. Signature and title of certifier	,			29c. License	number		29d. Date signed (Mon	th, Day, Year)
	- » F O		) (Manual)	1m4	-w	2	DI	950	2	April	10.200T
	0		30. Name and address of person who c	ompleted cause of d	eath (Item 23a	a) (Type,	Print)	Lan	Stron	A Xh	1/1001
_	V		Mannel M.	429	75	MI	2	Mory 1	any	21601	akt
	Sta		31. Date filed (Month, Day, Year)	32. Registr	ar's Signature	1		/	-		
	Regist	ar	APR 1 1 2005		17						

Registrar

State.

Avani D. Shah, M.D. 31. Date filed (Month, Day, Yan) 14 2

32. Registar's Signature

2005

22650 Cedar Lane Court Leonardtown, Maryland 20650

		•	For State Registrar	State	of Mary		artment of H		ind Me		ene	5	136	:02
	Physicia	an	1. Decedent's Name (First, Mid			T2 2-				2. Date of Death	Day \	/ear	3. Time o	
	/Medic	al .	Josefina  4a. Facility Name (If not institut.	A.		Edwards	4b. City, Town, o	or Location of		March 28,	2005 4c. County o	Death	9:30	рм
	Examin	er	Sligo Creek Nurs				Takoma		Death		Monto		7	
	Funeral		5. Social Security Number	6. Sex		yrs. last birthday)	If Under 1 Year	If Under 2		8. Date of Birth			lace (State etry)	or Foreign
	Director		220-58-7391	1 □ M 23€ F		89 Yrs.	Months Days	Hours	Min.	(Month, Day, July 13,			a Rica	
	pu *		Usual Residence of Decedent  10a, State 10b. Coun	tv	100	c. City, Town or Lo	ecation					1	0d. Inside (	City Limits
	Marylan f show	jo	Maryland	Montgomery		Çi1.	ver Spring							s 2 No
	rolli	Director	10e. Street and Number	rongonery			10f. Zip Code			10	g. Citizen of Wh	nat Coun	itry?	
	15 with		8505 Springvale	e Road			20910				τ	SA		
	ems erm	Funeral	11. Marital Status		ecedent Ever Forces?	in U.S. 13.	Was Decedent of H	Hispanic Orig	gin? (Spec , Puerto R	ify Yes or No- ican, etc.)	14. Race Black	Americ White		
36	be filed within 72 hours after death with the Maryland Hygiene. Hygiene. And other then "neturel", or items 23e or 28e-f show do other then "neturel", or items 23e or 28e-f show event, the Medical Examiner must be notified at	by Fu	1 Never Married 2 M 3 Widowed 4 Divorc	If Yes,			1 ☐Yes 2 ☐ No	Specify:	Costa	Rican	Specify:	Bla	_	
21215-0036	hour turel			ent's Education	r Dates:	16a. Dece	dent's Usual Occur	pation		1	6b. Kind of Bus	iness/Ind	dustry	
15	within 72 ene. then "ne	plet		nest grade complete	e (1-4or 5+)	(Give	kind of work done DO NOT use retire	during most ed)	of working	g			,	
21	filed with Hygiene ther the ant, the	Completed	6	, 55.109		Nur	rse Assista				Medic			
Maryland	be filed tal Hygi d other event, I	Be	17. Father's Name (First, Middle					18. Mothe		(First, Middle, N	laiden Sumame	)		
r <u>y</u> la	es 1 and 2 should be of Health and Mental f item 27 is marked o r other treumatic eve	2	Charles Edward  19a. Informant's Name/Relatio			10b Maili	ng Address (Street	and Alumba		ra Davis	City or Town S	tate Zin	Codel	
<u>⊠</u>	d 2 st th and th sis t7 is r treur	8 3									no associated	(at6, ZIP	C008)	
ď	Heal Heal tem 2	139	Ruth E. Burke/ 1 20a. Method of Disposition	vrece	2	Ob. Place of Dispo	torace Aver esition (Name of matory or other pla		Da	ite 2	20c. Location - C	ity or To	wn, State	
MO M	Pages ent of ry r. F. i		1 🔀 Burial 2 □ Crematio  1 □ Donation 5 □ Other		om State		eaven Cemet	1 -	April 4 200!		ilver Str	int	Marula	Der
Baltimore,	permit. Pages 1 Department of F Importent: If ite any injury or ot		21. Signature of Ineral Service	ce Licensee	1	$\mathbf{F}^2$	Name and Addr	SS of Facility		-	A	232	ruryio	IKI
<u> </u>	e la	10	Solut	11/	He	50	00 Universi	ty Blvd	1, W, S	Silver Sp	ring, Mar	yland	20901	
			23a. Part1. Enter the disease, shock, or heart failure. L	or complications the ist only one cause of	at caused the in each line.	death. Do not en	er the mode of dyi	ng, such as	cardiac or	respiratory arre	st,		Approxima Interval Be Onset and	etween
	Physician <sup>*</sup>		Immediate Cause (Final disease or condition resulting in death)	a. St	roke						· · · · · · · · · · · · · · · · · · ·		Year	
	/Medical Examiner		resulting in death)			nsequence of):								
		-	Sequentially list conditions,	b	heroscle	erosis						-	Year	<u>s</u>
	uted d ansit	Examiner	rany, laading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	<b>1</b> .										
oʻ	be executed sician and burial-transit		resulting in death) Last		to (or as a co	nsequence of):								
8760,	ate be ohysici the bu	dlcal		d										
9	death certificate be executed ie attending physician and sid for use as the burial-transif	0	IF FEMALE:	22c If yee	outcome of p	ragnancy						. 4 4 15		
Вох	eath certific attending p	Physiclan/M	23b. Was decedent pregnant in the past 12 months?	1 □Liv	re birth 2 [	Fetal death 3	Ectopic pregnance Other (specify)	y:			23d. Date Mont		Day	Year
0	at the de by the tached	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		nknown									
S, D	de de	by Pł	Part II. Other significant cond	itions contributing to	o death but no	ot resulting in the u	nderlying cause gi	ven in Part I.		23e. Did tob	acco use contrib	ute to th	ne cause of	death?
rds	equires en sign ould be	ed t	Arterial Hyper	tension						1 □ Ye	s 2⊠No 3	☐ Prob	ably 4	]Unknown
Record	law requas been 2 shoul	Completed								24a. Was an	/ pr	ere auto	psy findings	s available cause of
Ě		Com								perform 1 ☐ Yes 2	ned? de Mo 1	ath? ∃Yes	2 No	
Vital	Physicien: this certific ral director,	Be (	25. Was case referred to medi examiner?	Hospital:					of Death	(Check only one	9)			
of	Physi this al dir	2	1 Xes 2 No	1	☐ Inpatient ate of Injury	2 ER/Outpatie	II 3 DOA		-	e 5 Reside			v)	
	ding fth. After funer	tlon	1 DMatural 5 ☐ Pen	/A	fonth, Day Ye	ar) Injury	Wo	irk? ]Yes 2.∐1			,,			
Division	I or Attendated after death Director: /	ifica	3 ☐ Suicide 6 ☐ Cou	lid not be 28e. Pl	ace of Injury	At home, farm, st	reet, factory, office	1000	21	8f. Location (Str City or Town		or Rura	l Route Nu	mber,
ā	tel or Att s after d el Direct ed in by	Certification:	4   Homicide		uilding, etc. (S	преспу)				Oily or Town	, 3(4(4)			
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: Afte completely filled in by the fune			ying Physician: To al Examiner: On th										(s)
	the hin 24 the F	Medical	one) 29b. Signature and title of cert	and m	nanner stated.		29c. Licen				d. Date signed			
<b>\</b>	To Wit		10			- 1	DO8				pril 5, 2		,	
	2	13	30. Name and address of pers		ause of death	(Item 3a) (Type	Print)							
			Hugo Graziani,				lver Sprin	g, MD 2	0910					
	Sta	ate	31. Date filed (Month, Day, Ye											
* 10°	Regist	rar	APR 0	6 2003	BUNG	Signature								

			1 → For State Registrar	State of Mary	•	artment of rtificate of		Re	g. No.2 () () 5	13603
	Physici		1. Decedent's Name (First, Middle, Las Marianne Braund	•				2. Date of Death Month April	Day Year 2 2005	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town	, or Location of Dea		4c. County of Death	
			Ginger Cove Heal				Annapol		Anne Ai	
	Funeral Director		379-32-6853	ex 7. Age (In □ M 2XF 97	yrs. last birthday, Yrs.	Months Day				place (State or Foreign intry) ada
	land		Usual Residence of Decedent  10a. State 10b. County	100	c. City, Town or L	ocation				10d. Inside City Limits
	the Mary 28e-f sh	Director	Maryland Anne Anne Anne Anne Anne Anne Anne An	cundel		Annar		10	g. Citizen of What Cou	1 ☐ Yes 2 📉 No
	3a or	וםו	5302 River Crescer	t Drive		2140			United Sta	•
	death	Funeral	11. Marital Status	12. Was Decedent Ever Armed Forces?	in U.S. 13.			(Specify Yes or No- erto Rican, etc.)	14. Race - Amen	ican Indian,
5-0036	72 hours after death with the Maryland neturel', or Items 23a or 28e-f show deal Exant activities rediffed at		1 Never Married 2 Married 3 Widowed 4 Divorced	1 Yes 2 No If Yes, Give Year or Dates:		1 ☐ Yes 2 ☑ N		onto rican, etc.)	Specify: Wh	ite
215-0	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Importents: If item 27 is marked other then "neturel; or Items 23a or 28e-1 show any nighty or other treumatic event, the Medical Examination in the routilisal at once.	Completed by	15. Decedent's Ed (Specify only highest grant Elementary/Secondary (0-12)		(Give	edent's Usual Occ e kind of work don DO NOT use reti	ne durina most of w	rorking	6b. Kind of Business/Ir	idustry
21	filed within Hygiene. wher then "	Соп		3		Nurse			Nursing	
and m	be fill ad off	Be	17. Father's Name (First, Middle, Last)					ame (First, Middle, M.		
Maryland	12 should be filed within h and Mental Hygiene. 7 is marked other then "Ireumatic event, Ital Me.	ဥ	Edwin Braund  19a. Informant's Name/Relationship (	Type Print)	19h Maili	ing Address (Stra		et V. Spic	er City or Town, State, Zij	o Code)
N N	and 2 s salth an n 27 is i		Richard Drewyer /	** * *		_			napolis, M	
ē,	s 1 ar f Hea item other		20a. Method of Disposition	2	0b. Place of Disp		1		0c. Location - City or T	
Ë	Page nent o nnt: If try or		1  Burial 2  Cremation 3  C  1  Other (Specification			wn Cemet	· 1	7/2005 S	aginaw, Mi	chigan
Baltimore,	permit. Departn Importe any inju		21. Signature of Euneral/Service Lider	isee				John M. Ta cester St.		al Home, Inc s,MD 21401
	Physician // Medical Examiner phisician and purial-transit the prival-transit	Ical Examiner	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  S. quentially list conditions if any, leading to immediate cause. Enter 'Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a co	nsequence of):			0 (	£	Approximate Interval Batween Onset and Death
P.O. Box 68	The law requires that the death certifics the has been signed by the attending pt tage 2 should be detached for use as I	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2. No 9 ☐ Unknown	23c. If yes, outcome of pr 1 Live birth 2 4 Pregnant at time 9 Unknown	Fetal death 3	□Ectopic pregnar □ Other (specify)			23d. Date of deliv Month	rery Day Year
	uires that signed b	b	Part II. Other significant conditions of	ontributing to death but no	t resulting in the i	underlying cause	given in Part I.	23e. Did toba	acco use contribute to t : 2 No 3 □ Pro	the cause of death? bably 4 □Unknown
Records,	The law requir sate has been si page 2 should I	Completed						24a. Was an autopsy perform	24b. Were auto prior to co death? No 1 \( \subseteq Yes	opsy findings available ompletion of cause of
/ita	clen: ertific ector,	Be	25. Was case referred to medical examiner?	I de la constante de la consta				eath (Check only one		
of Vital	Physi this c al dire	To	1. Yes 2 No 27. Manner of Death		2 ER/Outpatie	nt 3 DOA		Home 5 Residen	ce 6 Other (Special	fy)
no	ding I h, After funer	tlon	1 Natural 5 Pending	28a. Date of Injury (Month, Day Yea	ar) Injury	W	vork? □ Yes 2 □ No	200. Describe nov	injury occurred	
Division	I or Attending Physiclen: after death. Director: After this certific in by the funeral director,	Certification:	2 Accident investigation 3 Suicide 6 Could not b 4 Homicide determined		At home, farm, st pecify)			28f. Location (Stre City or Town,	eet and Number or Run State)	al Route Number,
_	To the Hospitel or Attending Physicien: The within 24 hours after death. To the Funeral Director: After this certificate completely filled in by the funeral director, pag	edical Co		sysicien: To the best of my niner: On the basis of exa and manner stated.						
	Fo the Mithin Fo the Comple	Me	29b. Signature and title of certifier	0		29c. Lice	ense number	29	d. Date signed (Month,	Day, Year)
	- > F 0		) Jos	J. Ju		1	7 409	519	4/4/0	5
			30 Name and address of person who	completed cause of death	(Item 23a) (Type	, Print)	1	nter, Cer	- 1	
_			WIND W.W	soiree (6		Iton one	dical Co	wher, Cay	2) for -	
R	Sta Regist		31. Date filed (Moath PR), Year)	32 sistrar's \$	signature	Cardo o			53	

		1 - For State Registrar			or ivial ylal	-	artment of I rtificate of			ai 11)	Reg. No	20	05	13601
Physic	ian	Decedent's Nam	ne (First, Middi	le, Last)			2. Date of D Month				Da	ıy	Year	3. Time of Death
/Med	ical			FISHER						April	3	2	005	10:15 AM
Exami	ner		_	n, give street and nu			4b. City, Town,				40		y of Death	
Function		Genesis 5. Social Security		thCare -	The P			ston	r 24 Hrs.	8. Date of Bi	irth	T	albo	t place (State or Foreign
Funeral Director		213-38-2		1□M <b>2</b> (□F	90	Yrs.	Months Days	Hours	Min.	AUG 27	191	4	MAR	YLAND
land low		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or Lo					cation							10d. Inside City Limits
a-feh	tor	MD	TAT	LBOT EAST			ION							1∭Yes 2□No
72 hours after death with the Maryland naturel', or liems 23e or 28e-f ehow liteal Examinar must be routiled at	lrec	10e. Street and Number				10f. Zip Code					10g. Ci	tizen of	What Cou	ntry?
	la	700 PORT	ST.				2160					USA		
	ted by Funeral Director	11. Marital Status 1 ☐ Never Mar 3 🏋 Widowed	_	ied 1 □Yes 2.7NNo		Was Decedent of Hispanic Origin? (Specify Yes or N If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:				14. Race - American Indian, Black, White, etc.  Specify: WHITE			etc.	
72 hours "naturel".		/Cno	15. Deceder	's Education 16a. Deci		16a. Dece	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  EDUCATOR				16b. K	16b. Kind of Business/Industry		ndustry
permit. Pages 1 and 2 should be filed within 72 hours after de Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel", or Items any injury or other treumatic event, the Nedical Examinating Once.	Completed	Elementary/Sec 12	ondary (0-12)	College (	College (1-4or 5+) 5+							SECONDARY EDUCATI		EDUCATION
	Be	17. Father's Name		•						me (First, Middle, Maiden Sum		1 Sumar	me)	
	<sup>1</sup> 0	ISAAC A						MARY CUFF						
		19a. Informant's N					ng Address <i>(Street</i> 27823 PEM							,
		20a. Method of Dis	sposition			Place of Dispo	sition (Name of	T	- CANTAL	ate	-			
	П	1X Surial 2 `4 □ Donation	20a. Method of Disposition  1X Burial 2 Cremation 3 Removal from State  4 Donation 5 Other (Specify)  Applica of Disposition (Name of cemetery, crematory or other place)  MD VETERANS CEMETERY 4-7-2005  HURLOCK, MD											
		21. Signature of F		·		22	Name and Addre	ass of Facil	ity					
Pe C L C C C C C C C C C C C C C C C C C		You	メアド	MERC	FRO.	) FF	ELLOWS, H OO S. HAR	ELFEN	REIN	& NEW	I MAN	FUNE	RAL 1	HOME PA
		23a, Part1, Enter					LAI .C U	$r_{VT}$	SI	EASTON.	· MD	216	01	
Trysician /Medical		shock, or hea Immediate Cause disease or conditi resulting in death)	art failure. List (Final on	a	caused the deal	th. Do not ent	er the mode of dyin	ng, such as	S cardiac o	EASTON ,	, MD	216	01	Approximate Interval Between Onset and Death
		shock, or head immediate Cause disease or condition resulting in death)	art failure. List (Final on	a	caused the deat	th. Do not ent	er the mode of dyin	ng, such as	s cardiac o	EASTON , or respiratory a	, MD arrest,	216	01	Approximate Interval Between Onset and Death
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DHMH 17 Rev 1/2001

Elizabeth Fisher

State of Maryland / Department of Health and Mental Hygiene. 1 - For Stata Ragistrar Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month 4\_ April John Ferguson 2005 11:19AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince Georges Hospital P.G. Cheverly If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1**™** M 2□ F 50 Yrs Director 579-70-0991 10-4-54 D. Ĉ Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location show 10d. Inside City Limits treumatic event, the Medical Examiner must be notified at D.C. N/A Director Washington XXYes 2 No 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with ō 3500- 14th Street, N.W. #113 20010 Items 23e U.S.A. death \ Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. filed within 72 hours after of Hygiene. Ather then "neturel", or Iter Never Married 2 Married 1 ☐ Yes SETNo If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 should be filed w h and Mental Hygier 7 is marked other th 12th Unemployed None 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Archie Ferguson Mary Hill 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 sh Department of Health and Importent: If item 27 is m any injury or other treum ans. Mary Ferguson/Mother 3500- 14th St. NW #113 D.C. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Surial 2 □ Cremation 3 □ Removal from State
1 □ Donation 5 □ Other (Specify) 4/8/05 Maryland National Laurel, Md. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility The House of Williams Fun. Svc. 814- Upshur Street, N.W. llumo 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Congestive Heart Failure /Medical Due to (or as a consequence of): **Examiner** Hypertensive Cardiovascular Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed Arteriosclerotic Cardiovascular Disease Due to (or as a consequence of): burial-1 Box 68760. Physiclan/Medical the IF FEMALE esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? ło Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown þ signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes XXNo 1 🗌 Yes 2 No Hospitel or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) examiner Cther: Certification: To 1 ☐ Yes 2 📆 No 1 Inpatient 2€R/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred **X** atural 5 Pending 1 ☐ Yes 2 ☐ No investigation death 2 Accident after death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) þ 4 Homicide filled in 29a. Certifier Medical Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated, 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 To the the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D27577 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ophnell Cumberbatch, 8416 Central Ave. Landover, Md. 20785 M.D. 32. Resstrar's Signature State Registrar

			1 = For State Registrar	State of Mai	ryland / De		lealth and M		ne nos	13606		
	Physici /Medic Examir	cal	1. Decedent's Name (First, Middle, Last)  2. Date of Death  3. Time of Death							6230 M		
	Funeral Director		5. Social Security Number 6. S 351-14-8887  Usual Residence of Decedent	(In yrs. last birthda 104 Yrs.			8. Date of Birth (Month, Day, Ye Jul. 4,	Date of Birth (Month, Day, Year)  u1. 4, 1900  9. Birthplace (State or Foreign Country)  KS				
	e Maryland Sa-f show	To Be Completed by Funeral Director	10a. State 10b. County 10c. City, Town or Location					10d. Inside City Limits 1 □ Yes 2€ No				
	h with th		10e. Street and Number 27 Emerson Road		10f. Zip Code 211	46	10g. Citizen of What Country? USA					
920	d within 72 hours after death with the Maryland jene. Ir than "natural", or fams 23a or 28a-1 show The Medical Examiner must be notified at		11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Ev Armed Forces? 1 ∐Yes 2∑No If Yes, Give Year or Dates:		B. Was Decedent of Hif Yes, specify Cub	dispanic Origin? (Spe an, Mexican, Puerto I Specify:	cify Yes or No- Rican, etc.)	fy Yes or No- can, etc.)  14. Race - American Indian, Black, White, etc.  Specify: White			
Maryland 21215-0036	hin 72 h		15. Decedent's Ed (Specify only highest grant Elementary/Secondary (0-12)	lucation de completed) College (1-4or 5+)	(Giv	cedent's Usual Occup ve kind of work done DO NOT use retire	pation during most of workind)	g 16b. Kind of Business/Industry				
d 21	m (5 to 60)		17. Father's Name (First, Middle, Last)		Homen		(First, Middle, Mai	Home irst, Middle, Maiden Surname)				
ylan	should be and Mental marked o		Ed O'Brien				Lillian	Cullins				
	1 and 2 sho Health and am 27 Is m		19a. Informant's Name/Relationship (7 Shirley Masiee/I	** *			and Number or Rura Road, Seve:		ity or Town, State, Zi <sub>l</sub> MD 2114			
Baltimore,	permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 Is marked otha any injury or othar traumatic avant, once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specify		cemetery, cr	position (Name of rematory or other place Beach Mem.	unk D		c. Location - City or To Boyton Beac			
Balti	permit. Pages. Department of H Important: If ite any injury or of once.		21. Si, lature of runeral Service Licen	Som	I L	Barrandoda 195 Gov. R	ss Sons, P.A Litchie Hw	A. Severn	a Park Fu a Park, M	neral Home O 21146		
I	Physician		495 Gov. Ritchie Hwy, Severna Park, MD 21146  23a. PArt 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Approximate Interval Between Onset and Death  Approximate Interval Between Onset and Death									
	/Medical Examiner	dical Examiner	resulting in death)		consequence of):							
ecuted	be executed ician and burial-transit		Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last									
8760,	ys e		d									
P.O. Box 6	Box 6 ath certif		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑No 9 □ Unknown  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) □ □ Unknown						23d. Date of delivery Month Day Year			
	Records, The law requires ate has been sign page 2 should be	ed by Physician/Med	Part II. Other significant conditions continuously to death but not resulting in the underlying cause given in Part I.					23e. Did tobacc	Did tobacco use contribute to the cause of death?  1 ☐ Yes 2 ☑ Yo 3 ☐ Probably 4 ☐ Unknown			
II Reco		To Be Completed	24a. W ar p. p. 1 🗍 Ye						topsy prior to completion of cause of death?			
Vita	Physician: this certific ral director,		25. Was case referred to medical examiner? 1 ✓ Yes 2 □ No	Hospital: Other					(Check only one) e 5 X esidence 6 □Other (Specify)			
Of Phy rthis rald	Attending Phy r death. actor: After thi by the funeral o		This patient 2 Live outpatient 3 DOA 4 Nutsing Notice 5						Describe how injury occurred			
Division	af or Atteness after death	Certification:							Location (Street and Number or Rural Route Number, City or Town, State)			
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	edical C	29a. Certifier (Check only one)  1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
)	To the within To the comp	Me	29b. Signature and title of certifier  Control of the signature and title of certifier  Control of the signature and (Month, Day, Year)  Control of the signature and title of certifier  Control of the signature and (Month, Day, Year)									
			30. Name and address of person who	completed cause of dea	th (Item 23a) (Type		55 A	DAPICIO	CA D1	035		
	Sta Registr		31. Date filed (Month, Day, Year) APR 0 5	32. Registrar's		food		merte				

State of Maryland / Department of Health and Mental Hygiene ( Certificate of Death Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death **Physician** Apri 200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Annapoli'S ter 1 Year of Under 24 Hrs. at 5. Social Security Number 6 Sax 7. Age (In vrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Hours Year) 187 M 2 F 217-12-0693 81 Director 18,1923 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at MD Anne Arundel Director Annapolis 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7101 Bay Front Drive or Items 23a 21403 12. Was Decedent Ever in U.S. Armed Forces? 1 Styles 2 □ No WW II tyles, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-tf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black. White, etc. within 72 hours after 1 ☐ Never Married 2 🔀 Married Maryland 21215-0036 λ 1 ☐ Yes 2 ☑ No Specify: White Specify: 3 ☐ Widowed 4 ☐ Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If item 27 is marked other than ' Elementary/Secondary (0-12) Coltege (1-4or 5+) Mail Carrier 10 Postal 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Thomas Finn Catherine Norton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret E. Finn/Wife 7101 Bay Front Drive Annapolis, MD 21403 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any inlury or ot once. April 5, 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Lorraine Park Cemetery 2005 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Barranco & Sons, P.A. 495 Gov. Ritchie Hwy. Thomas Severna Park Funeral Home Severna Park, MD 21146 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between tmmediate Cause (Final Onset and Death **Physician** moth disease or condition resulting in death) /Medical Due to for as a consequence of) Examiner 400 f Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a co Examiner certificate be executed and Due to (or as a consequence of): burial-1 Box 68760, attending physician for use as the buris Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 4□Pregnant at time of death 5 Other (specify) P.O. P ed by the a 9 Unknown n signed by th. 1 be der 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 s has autopsy certificate Division of Vital 2 No Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 115515ted Hospital: Other: 4 \( \) Nursing Home \( 5 \) Residence \( 6 \) ther (Specify 1 ☐ Yes 2 No P 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27 Manner of Death 28b. Time of 28c. Injury at Work? Certification: After 5 Pending investigation 1 Natural 2 Accident death. 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: completely filled in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ō 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) and address of person who completed cause of death (Item 23a) (Type, Print Glen Burnie Madison Nuseitee egistrar's Signatur 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item 18 per dvr 8842 4-20-05 vt Amend Item 25 geravers, 8842 the 21/05 diff and Mental Hygiene 1- State Registrar AMEND ITEM #19a PER FH C843C9/725/745 Off Death Reg. No. 2 Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year **Physician** April 1243M SAMUEL LEE FOREMAN 2 2005 /Medical 4c. County of Death 4b City Town or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Salistin Hicomics Regional per 6. Sex Pedical Cente eninsula Year If Under 24 Hrs. 52 7. Age (In yrs. last birthday) Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Min 220-52-1058 1 XM 2 ☐ F Yrs. Director 55 May 5, Maryland 20-Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a State 10h County 10d. Inside City Limits 28a-f show traumatic event, the Madical Examinar must be notified at 1 ☐ Yes 2 🖾 No Directo Maryland Worcester Newark 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 5 6538 Bowden Road 21841 USA Items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 72 hours after 1 X Never Married 2 ☐ Married ō Specify: Black 1 ☐ Yes 2 🔀 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Rman "neturel", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Roland E. Powell Conven. 15. Decedent's Education (Specify only highest grade completed) l Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Center 12th Foreman/Supervisor of Operat. and Mental Hygie Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be P Purnell Helen Foreman Foreman 2 John 19a. Informant's Name/Politicachia (Type Print)
Samuel T. Bowen/son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is eny injury or other trains once. 9526 Bottle Branch Road - Berlin, MD 21811 amma 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ₺ Burial 2 □ Cremation 3 □ Removal from State `4 □ Donation 5 □ Other (Specify) Wms Church Ceme. 04/18/2005 Newark, Maryland 22. Name and Address of Facility 1213 Jersey Road - Salisbury, MD 21. Signature of Funeral Service Licenses JOLLEY MEMORIAL CHAPEL Pant Ext of the disease, or complications that caused the de /h. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or failure. List only one cau, on each line. Approximate Interval Between Onset and Death Immediate Cause (Final INTRAVENTRICULAR Physician 464 WRILLIAGE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ANGURYSMS COLGISELLAR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine be executed nding physician and use as the burial-transit Due to (or as a consequence of): 68760 Physician/Medical requires that the death certificate the attending p Box IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ð HYPERTENSION 1 Yes 2 No 3 Probably 4 Vunknown Completed page 2 should 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has certificate 1 Yes 2 No Division of Vital Hospitel or Attending Physicien: director 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2√2 No this After this funeral c 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Injury 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after deatl To the Funerel Director: 6 Could not be determined 3 🖺 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) by ; 4 Homicide pellil 29a. Certifie 💢 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only onel To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified APRIL 13, 2005 05733 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Salisbury, MD 21801 rierre 100 E. Carroll 31. Date filed (Month, Day, Year) 32. Registrar's Signature State APR 2 Registrar Goods

2298	3		For State Registrar	State of	Maryland / De	epartment Certificate			and Me		giene Reg. No.	11115	13609
			Decedent's Name (First, Midd	lie, Last)					2.	. Date of Dea	ith		3. Time of Death
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	/Medic Examin		4a. Facility Name (If not institution	-	ber)	4b. City, T	Town, or	Location o	of Death		4c.	County of Deat	
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	Funeral		5. Social Security Number	6. Sex 7 1 🔀 M 2 🗆 F	'. Age (In yrs. last birtho ΔQ Yr	Months	1 Year Days	If Under	Min. 7	Date of Birtl (Month, Day pril	h / Ye <i>ar)</i>	9. Birt	hplace (State or Foreign nuntry)
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Maryland	and and is m		19a. Informant's Name/Relation			3	,					or Town, State, 2	
	1 and Health em 27 ther to		Giselle M. Gl	leason (s	ister) 2		_	er Vi	ew L			apolis	MD 21401
Ö	ges 1 t of H if ite or ot		20a. Method of Disposition 1 ☐ Burial ★★Cremation		cemetery	cramatory or of	ther place	e)					
Baltimore,	t. Pa ntmen rtant;		*4 □ Donation 5 □ Other (	Specify)		22. Name and		1	•	,	DOV	er, DE	
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9	tificete ng physi as the l	ě l									-		<i>∞</i>
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ō	Phys ar this aral di	7: To	27. Manner of Death	28a. Date o	of Injury 28b. Tie		28c. Injui Woi			3d. Describe			at scene
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	o i s	~	29b. Signature and title of certif	A IV	1111	230		ME				il 2, 20	
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	0		30. Name and address of person	1 1 1 1 1	e of death (Item 23a) (T		1 Pe	nn St	reet	Balti	more	e. Marvl	land 21201
	C+	ate	31. Date filed (Month, Day, Yea	ar).	egistrar's Signature	<b>6</b>						, , , , , , ,	
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No... 1. Decedent's Name (First, Middle, Last) 2. Date of Death 03 **Physician** 2005 29 9:00p M Shirley J. Garber /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Road Talbot 21592 Donnell Jones Sherwood If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) United the country of the country 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 💢 F Months Director 202-16-5562 80 Usual Residence of Decedent with the Maryland show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Itams 23a or 28a-f show The Medical Examiner must be notified at Md Talbot Sherwood 1 Yes 2 No Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21665 21592 Donnell Jones Road USA filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Xves 2 No If Yes, Give Year or Dates: 44-48 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: SpecifyWhite þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Chemical Processor Electronic 12\_years other traumatic avant. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental I Pages 1 and 2 should be ment of Health and Menta Nora M. Witmer Clarence L. Demmy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21592 Donnell Jones Rd. Sherwood, MD21665 Norma J. Newcomer (daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State ö permit. Page Department of Important: If any injury or once. Riverview Burial Park 4-9-2005 Lancaster,Pa. ` 4 ☐Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility R. Carroll Hurley Funeral Home, PC 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Evaruan 2 months /Medical Due to (or as a consequence of): Examiner Astlma Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of The law requires that the death certificate be executed the attending physician and hed for use as the burial-tran Due to (or as a consequence of) Division of Vital Records. P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown perlension Be Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? has pothyroid. page certificate 1 Yes 2□ No 2**)** No 1 TYes Hospital or Attanding Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Injury Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation after death 3 🗌 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide 🖄 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) 4723 Shutos 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mary S. Deshields, MD 509 Idlewild Ave., Easton, Md. 21601 31. Date filed APR 0. 4 2005 State Registrar

			1 - For State Registrar	State of Maryla		artment of			iene	13611
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	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs	s. last birthday)	If Under 1 Year	If Under 24 Hrs			place (State or Foreign ntry)
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Baltimore,	permit. Departn Importa any inju		21. Signature of Funeral Service License	8		2. Name and Addr	ess of Facility	neral Home,		,
_	205 20		23a. Part I. Enter the disease, or complic	nen	P.	0. Box 270	, Leonardt	own, Marylai	nd 20650	
8760,	American and hysician and hysician and hysician and hysician and hysician signature.	al Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Einer Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conse	quence of):	gr Ac	CIDENT			Onset and Death
P.O. Box 687	t the death certific by the attending p ached for use as	Physician/Medical	in the past 12 months?  1 Yes 2 No	ic. If yes, outcome of pregr 1	al death 3 death 5	Ectopic pregnanc Other (specify)	,		23d. Date of delive Month	Day Year
	uires tha signed I	by	Part II. Other significant conditions con	tributing to death but not re	sulting in the u	nderlying cause gr	ven in Part I.		acco use contribute to th s 2 ☑Mb 3 ☐ Prob	ably 4 Dunknown
00r	w requ been should	etec	DEW ENTIA	Ston				24a. Was an		
al Records,	The ate h page	Completed						autopsy	prior to cor ed? death?	psy findings available inpletion of cause of 2 No
Vital	Physician: this certificatal director,	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	ospital:	☐ ER/Outpatier	ot 30004 Ot		ath (Check only one	nce 6 Other (Specif)	
ion of	ding h. After fune	atlon: T	27. Manner of Death  1 Matural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Inju Wo		28d. Describe hor		,,
Division	200	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Spec	nome, farm, str ify)	eet, factory, office		28f. Location (Str. City or Town,	eet and Number or Rura State)	l Route Number,
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	edical	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	ician: To the best of my kn er: On the basis of examin and manner stated.	owledge, death ation and/or in-	n occurred at the ti vestigation, in my	me, date and place opinion, death occi	e, and due to the ca irred at the time, da	use(s) and manner as st te and place, and due to	ated. the cause(s)
	To the within To the comp	ğ	29b. Signature and title of certifier	k	. >	29c. Licen	_	29	d. Date signed (Month,	Day, Year)
)	SAO		1 fell		(1)		6096		4.12.05	
	U		30. Name and address of person who could be a second of the country of the countr	npleted cause of death (Ite	m 23a) (Type,	Print)	1toniy	WEDD	MD 206	36
	Sta Registr	te ar	31. Date filed (Month, Day, Year) APR 1 2	2005	ature &	Such				

<b>Physici</b>		1. Decedent's Name (First, Middle	e, Last)	Maryland / 28a f per				2.	Date of Death		. 200	3. Time of
/Medic			Byron J	James Guy	7				APRIL	$\frac{1}{17}$ , 2	005	8:40A
Examin		4a. Facility Name (If not institution ST. MARYS HOSPIT		ber)	4	4b. City, Town, or	r Location o	of Death		4c. County		
		5. Social Security Number		. A	tion to N	LEONAL If Under 1 Year				ST.MA		
uneral irector		216-06-5577	6. Sex 7 1 ★ M 2 ☐ F	7. Age (In yrs. last t 21		Months Days	Hours	Min.	Date of Birth (Month, Day, )		Cou	
		Usual Residence of Decedent					1 1	1110	vember 3	0,1983	Mar	yland
wow.	_	10a. State 10b. County		10c. City, To	own or Loca	tion						10d. Inside Cit
or 28a-f show s notified at	cto	Maryland Saint	Mary's_	C1em	nents							1 🗌 Yes
or 2 be in	Director	10e. Street and Number				10f. Zip Code			100	g. Citizen of V	Vhat Cour	ntry?
s 236	Funeral	24727 Budds Creek		fort Every's ILO	10 101	20624				USA		
ritam	Fun	11. Marital Status  1 ☑ Never Married 2 ☐ Marri	Armed Ford		13. Wa	s Decedent of Hi es, specify Cuba	lispanic Orig an, Mexican	gin? (Specifi i, Puerto Ric	/ Yes or No- an, etc.)	14. Hace Blac	e - Americ k, White,	can Indian, etc.
al', or	þ	3 Widowed 4 Divorced	If Yes, Give Year or Dat	, —	1 🗆	Yes 2⊠ No	Specify:			Specify	Whit	e .
natur	Completed	15. Decedent (Specify only highes	t's Education	16	Sa. Deceden	nt's Usual Occupa	ation		16	Bb. Kind of Bu	siness/In	dustry
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har th	S	12	4 - 2		HVAC 1	Mechanic				Heating		<u> </u>
ad ot	Be	17. Father's Name (First, Middle, I	•				18. Mothe	r's Name <i>(F</i>	irst, Middle, Ma	iden Sumam	θ)	
mark	2	Raymond Patrick (  19a. Informant's Name/Relationsh	. ,	- 1	Oh Mailfa-	Address (Ct		Ellen				
Constitution of the state of th	1	Raymond Patrick Guy				Address (Street a						Code)
tam 2		20a. Method of Disposition	y / Father	20b. Place	of Dispositi	udds Creek on (Name of		Clemer Date		1and 206 c. Location -		own. State
nt: If		1 XXBurial 2 ☐ Cremation '4 ☐ Donation 5 ☐ Other (Sp		late	-	tory or other place ial Garde	1	Apri	1			
inju	1	21 Signature of Funeral Service L		7 .	22. N	lame and Addres	ss of Facility	21, 20		eonardto	wn, M	laryland
any ir	1 10	Mickael	forele	ner	Matt	tingley-Ga Box 270,	rdiner	Funera	1 Home,	P.A.		
		23a. Part1. Enter the disease, or shock, or heart failure. List of	complications that cau	used the death. Do								Approximate
sician				GI IIIIO.			3,	04,014,00	spiratory arrest	,	1	Onset and De
edical		Immediate Cause (Final disease or condition resulting in death)	Methado	ne intox	icatio				-		ocai	Onset and Dr
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			For State Registrar	State of Ma	aryland		artment of H				iene	5	136	13
			Decedent's Name (First, Middle, La	ist)						2. Date of Deat	1		3. Time of	Death
	Physici /Medic		DONALD	GORDO	v. S	R.				Month APRIL	5, 20	Year ∩5	3:20	ам
-	Examin		4a. Facility Name (If not institution, give		.,, .		4b. City, Town, or	Location of	of Death		4c. County		3.20	
			ANNE ARUNDEL ME	DICAL CENT	FT?		ANNA	POLIS	3		ANNE	ΔRII	MDET	
	Funeral		5. Social Security Number 6. S			ist birthday)	If Under 1 Year	If Under	24 Hrs.	8. Date of Birth			place (State or etry)	r Foreign
ш	Director		275-34-0112	1 <b>3</b> M 2 □ F	65	Yrs.	Months Days	Hours	Min.	(Month, Day, Sept 30	1939	Coui	hio	
	P		Usual Residence of Decedent											
	arylar show	_	10a. State 10b. County		10c. City,	Town or Lo	cation					1	0d. Inside Cit	
	Ba-f s	ç	Md. Prince	George's			Bowie						1 X Yes	2 🗌 No
	or 2	Director	10e. Street and Number				10f. Zip Code			10	g. Citizen of W	hat Cour	ntry?	
	23e	ra	3800 Enfield Ch					20716	5		Unite	d St	ates	
	tems	Funeral	11. Marital Status	12. Was Decedent I Armed Forces?	ver in U.S	13.	Was Decedent of Hi f Yes, specify Cubar	ispanic Origin, Mexican	gin? (Spec	cify Yes or No- Rican, etc.)		- Americk, White,	an Indian,	
36	be filed within 72 hours after death with the Maryland that Hygiene. Id other than "netural", or items 23e or 28a-f show event, it e Madical Examination that be notified at	by Fi	1 Never Married 2 Married	1 StYes 2 □ N If Yes, Give	lo	1	1 ☐ Yes 2 ဩ No	Specify:			Specify:			
Ş	hour tural	pe pe	3 Widowed 4 Divorced	Year or Dates:		10 0						BT	ack	
5	n 72	Completed	15. Decedent's E (Specify only highest gr	ade completed)		(Give	dent's Usual Occupa kind of work done d DO NOT use retired.	turina most	t of workin	ng 1	6b. Kind of Bu	siness/In	dustry	
7	within ene. than "	шć	Elementary/Secondary (0-12)	College (1-4or 5	+)	me	· ·				M.			
9	e filed within al Hygiene. I other than ' vent, it e Me	e Cc	17. Father's Name (First, Middle, Last				Ministe		er's Name	(First, Middle, M		nist	гу	
an	d be antal ced c	<b>CD</b>	Arthur Gordon									5)		
Maryland 21215-0036	2 should be and Mental Is marked e	2	19a. Informant's Name/Relationship (	Type, Print)		19b Mailir	ng Address (Street a	and Numbe		a Carter		Stato Zin	Codel	
S	교 등 시 글 다		Doris Gordon /	Wife			Enfield C			Bowie,		0716	Code	
Baltimore,	permit. Pages 1 and Department of Heall Important: If item 2 any injury or other and once.		20a. Method of Disposition				sition (Name of natory or other place		4.1		Oc. Location - (		wn. State	
20	ages ant of t: If i		1 ☑ Burial 2 ☐ Cremation 3 ☐  `4 ☐ Donation 5 ☐ Other (Special					1	/ 1			•		
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Ь	670		23a. Parti. Enter the disease, or com shock, or heart failure. List pniv Immediate Cause (Final	one cause on each lin	е.		1	g, 300/1 us (	ourdiac or	respiratory arre.	st,		Interval Betw Onset and D	een
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	0.00	<u>~</u>	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	conseque	ence of):						_		
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Вох	that the death certific ed by the attending p detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome							23d. Date	of dolive	n,	
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o.	the cy the	ysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown										
σ.	that ned b		Part II. Other significant conditions of	ontributing to death bu	t not result	ting in the ur	iderlying cause give	n in Part I.		23e. Did toba	cco use contril	bute to th	e cause of de	ath?
ds,	urres n signe	d by								1 🖫 Yes	2 □ No :	3 🔲 Prob	ably 4 🗍 Ur	iknown
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Be	he lav e has ige 2:	m								autopsy	pr	ior to cor	osy findings av npletion of cau	use of
		o C	2E. Was agen referred to modical							1  Yes 2 (	JNo 1[	∃Yes	2□ No	
	sicia cert irect	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ №6	Hospital:		20	Otho	e-		(Check only one				
Division of	E E =	$\vdash$	27. Manner of Death	28a. Date of Injur	/ 2	R/Outpatient 8b. Time of	t 3□ DOA Surv	4 🗆 Nul		e 5 🗆 Residen			)	
o	ding I h. After funer	‡ Ç	1 ☐ Matural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	Year)	Injury	Work'	? ′es 2 🔲 N	16		injury occurre			
/S	r Attending Physician: er death. rector: After this certific. by the funeral director.	ertification:	3 ☐ Suicide 6 ☐ Could not b	e 28e. Place of Inju	ry - At hom	ne, farm, stre				3f. Location (Stre	et and Number	r or Bura	Route Numb	er
á	afte Dir	erti	4 Homicide determined	building, etc	(Specify)		,,			City or Town,				,,,
	Hospital or Atteno 24 hours after death Funeral Director: tely filled in by the	a C	29a. Certifier 1 Certifying Ph	ysician: To the best o	my knowl	edge, death	occurred at the time	e, date and	d place, an	nd due to the cau	se(s) and man	ner as st	ated.	
	e Ho 1 24 } 1e Fu	edical	(Check only 2 Medical Examone)	niner: On the basis of and manner stat	examinatio	n and/or inv	estigation, in my opi	inion, death	h occurred	d at the time, dat	e and place, ar	nd due to	the cause(s)	
	To the Hospital or within 24 hours afte to the Funeral Dir completely filled in 1	Me	29b. Signature and title of certifier	1			29c. License	number		290	I. Date signed	(Month, I	Day, Year)	
				Monday	/	000	/) ?	X44	15	A	1001		260	2
1	15)	1	30. Name and ad ress of person who	completed cause of de	ath (Item 2	23a) (Type. f	Print)	1	-	V	1 1 1 1 1	2	10	-
-			Tra IN	FINITE	11	600	Rille	1/11	, 191	10 1	Fone	noh	, m	2
	€ - Stat	te	31. Date filed (Month, Day, Year)		r's Signatu	- 6				6	/	- V 1 1		
	Registra	ar	APR 0 8 2005	Blein	K	Break								

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death <sup>Day</sup> 2005 April 3, **Physician** Year 4:25 p Catherine Grierson /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Calvert Memorial Hospital Prince Frederick Calvert 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months Days Hours 1 □ M 2 1 F Yrs Director 219–16–1139 Mar. 1, 1925 80 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits other traumatic event, the Medical Exeminer must be notified at 1 ☐ Yes 2 XNo Directo Maryland Calvert North Beach 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 3807 6th 20714 Street U.S.A. or items 23a 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: white 3 ☐ Widowed 4 ☑ Divorced natural 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 7 Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) waitress restaurant 11 permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie Important: If Item 27 is marked other? 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert Morris Smith Katherine Watson ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol Lynn Cress, daughter 3807 6th Street, North Beach, MD 20714 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Femoval from State
1 ☑ Donation 5 ☐ Other (Specify) So. Memorial Gardens 04/07/2005 Dunkirk, MD of Funeral Service Licen: 22. Name and Address of Facility Rausch Funeral Home, P.A., Owings, MD wach 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** a Septic Shock and Bactremia due to Streptococus Pneumoniae /Medical Examiner neumonia with pleural effusion Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Box 68760 Physician/Medical the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4 Pregnant at time of death 5 Other (specify) Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Chronic Lymphatic Leukemia 1 Yes 2 No 3 Probably 4 Ponknown Completed Decubitus Dicer. 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No HYPOProteinemia 2 PNo of Vital 1 Yes To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P 1 ☐ Yes 2 ☑ No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: Division 1 Natural 5 Pending Injury death. 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: 6 Could not be determined 3 🗍 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a To the Funeral I 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) cai 29a. Certifier (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) yan 50653 surana. 4-3-2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GYAN - C. SURANA 5851-Deale Churchton Road Deale mp. 31. Date filed (Month, Day, Year) 32. Registros Signature State 8 2005 > Boson & Sparke

DHMH 17 Rev 1/200

Registrar

-	•	-	1 - For AMEND#1 per phy. Amend of Maryland 1. Pl State Registrar 4/5/05 ANNE ARUNDEL CO HEALTH DEPT	Jenificate of Death	atal Hygien	<b>2</b> 005 13615
	Physicia		1. Decedent's Name (First, Middle, Last) Grace Florin	Gaffney 2.	Date of Death Month Da	ay Year 072 5 M
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death Severum PA	rK 4	c. County of Death  A  A
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birth	day) If Under 1 Year   If Under 24 Hrs. 8.  Months Days Hours Min.	Date of Birth (Month, Day, Year 11, 20, 1	
			Usual Residence of Decedent         10a. State         10b. County         10c. City, Town			10d. Inside City Limits
	e Mary 3a-f she	Director	MD Anne Arundel	Severna Park		1 ☐ Yes 2 🙀 No
	with the Sa or 2 at the mo		10e. Street and Number  1039 Rio Lane	10f. Zip Code 21146	10g. C	itizen ol What Country? USA
36	72 hours after death with the Maryland natural; or tems 23a or 28a-f show disal Examinar must be notified at	by Funeral	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specifit Yes, specify Cuban, Mexican, Puerto Ric	y Yes or No- an, etc.)	14. Race - American Indian, Black, White, etc.  Specify: White
21215-0036	C . 30	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  Ita Processing Trainer		Kind of Business/Industry ate of Maryland
	othe rent,	O	12 Da	18. Mother's Name (F	irst, Middle, Maide	on Sumame)
Maryland	T T T T	To B	Elmer Thomas Stout		Roberson	
Mar	7505			Mailing Address (Street and Number or Rural F 139 Rio Lane, Severna		21146
altimore,	of H		1   Burial 2 M.Cramation 3   Hemoval from State	Disposition (Name of crematory or other place)  Crematory  Apr.	6, Ba	Location - City or Town, State
Balti	permit. Pag Depertment Importent: I any injury o once.		21. Sum Ture of Ture ral Service Licensee	Baltandows Sons, P.A 495 Gov. Ritchie Hwy	. Severna , Severna	a Park Funeral Home a Park, MD 21146
	Wedical Examiner  (be executed / Medical   Med	Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each fine.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list corrollions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	e Heart Fai levotic Hear- n:	luve + Dis	Approximate Interval Batween Onset and Death
P.O. Box 68760,	The law requires that the death certificate be ex ate has been signed by the attending physician page 2 should be detached for use as the buria	Physician/Medical E	d	3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delivery Month Day Year
	ires tha signed d be de	by	Part II. Other significant conditions contributing to death but not resulting in Fracture Pelvis	the underlying cause given in Part I.	23e. Did tobacco	o use contribute to the cause of death?  2 □ No 3 ② robably 4 □ Unknown
Records,	The law requir ste has been si age 2 should	Completed	Tracture retruit		24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
Vital	Physicien: The la this certificete ha ral director, page 2	Be	25. Was case referred to medical examiner?  Hospital:	26. Place of Death (	1098211	- To: (0 / 1)
Division of	ding Phy n. After this funeral d	Certification: To	27. Manner of Death 28a. Date of Injury 28b. T (Month, Day Year) In Natural 5 □ Pending (Month, Day Year)	ime of jury Mork?  M 1 Yes 2 No Sing Folia	d. Describe how inj	1 9 Fell on Floor and Number or Rural Route Number,
_	To the Hospitel or Attentwithin 24 hours after deatl To the Funerel Director: completely filled in by the	edical C	29a. Certifiler (Check only one)  1 Certifying Physicien: To the best of my knowledge, 2 Medical Exeminer: On the basis of examination and and manner stated.	death occurred at the time, date and place, and lor investigation, in my opinion, death occurred	d due to the cause at the time, date a	(s) and manner as stated. ind place, and due to the cause(s)
)	To th within To th compl	Me	29b. Signature and title of certifier  Dep	29c. License number 050000005050		Date signed (Month, Pay, Year)  4   4   5
			30. Name and address of person who completed cause of death (Item 23a) ( William P. Senes, m.	Type, Print) D000605	vica	21035
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)  APR 0 5 2005	front		

			1- For State of Maryland / Dep Registrar Co	partment of Health and Iterificate of Death		ene <sub>J</sub> . No.
	Physici /Medic		1. Decedent's Name (First, Middle, Last)  Robert Stephen Grace		2. Date of Death Month April 2,	Day Year 3 Time of Death
	Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
		ų.	4842 Willows Road	Chesapeake Beach		Calvert
	Funeral Director		5. Social Security Number  202-18-2021    Sex   7. Age (In yrs. last birthda   77   77   77   77   77   77   77	y) If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	(Month, Day, Y	9. Birthplace (State or Foreign Country) 1927 Pennsylvania
	/land		10a. State 10b. County 10c. City, Town or	_ocation		10d. Inside City Limits
	B-f sh	tor	Maryland Calvert Chesape	eake Beach		1 ☐ Yes 2X No
	ith the	Jirec	10e. Street and Number	10f. Zip Code	10g	. Citizen of What Country?
	s 23a	rai	4842 Willows Road	20732		U.S.A.
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, I're Modical Exertifier must be nuitlied at once.	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Married  1945-46	. Was Decedent of Hispanic Origin? (S) If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☒ No Specify:	pecify Yes or No- o Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: white
Ö	72 hou	ted	15. Decedent's Education 16a. Dec	edent's Usual Occupation	16	b. Kind of Business/Industry
21215-0036	ithin 7	Completed	(Specify only highest grade completed) (Gin Elementary/Secondary (0-12) College (1-4or 5+)	re kind of work done during most of work DO NOT use retired)	king	
	fygier her th		17. Father's Name (First, Middle, Last)	Priest		atholic Church
Maryland	d be fi	) Be	Stephen William Grace	Florence	ne (First, Middle, Ma	Miles
2	should nd Me mark mark	<sup>C</sup>		ling Address (Street and Number or Ru		
	alth a			Windsor Court, Gle		
altimore,	es 1 a of He fitem r othe		20a. Method of Disposition 20b. Place of Dis	The state of the s		c. Location - City or Town, State
Ĕ	Pages ment of ant: If its ury or o		1X Burial 2 □ Cremation 3 □ Removal from State  '4 □ Donation 5 □ Other (Specify)  Immaculat	e Heart of Mary 0	4/07/05 Li	inwood, PA.
Ball	permit Depart Import any inj		1.100.	22. Name and Address of Facility Rausch Funeral Home	e, P.A., (	Owings, MD 20736
П			23a. Part1. Enter the disease, or complications that cadeed the death. Do not e shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac	or respiratory arrest	Approximate Interval Between
	Pnysician	, y	Immediate Cause (Final disease or condition and the condition and	ncer, metast	atio	Onset and Death inen His
	/Medical Examiner		resulting in death)  Due to (or as a consequence of):	7 //		
		er	Sequentially list conditions, if any leading to immediate b.  Due to lor as a consequence of			
	d d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events			
o,	be execute sician and burial-trans	Exa	resulting in death) Last Due to (or as a consequence of):			
8760,	icate be executed physician and the burial-transit	dicai	d			
9		/Mec	IF FEMALE:			
Box	death certifi e attending id for use as	Physician/Me	II the past 12 months:	☐Ectopic pregnancy ☐ Other (specify)		23d. Date of delivery  Month Day Year
o.	0 0 0	ysic	1 Li Yes 2 Li No 9 Li Unknown			
ري. ح	The law requires that the de sie has been signed by the page 2 should be detached	by Pl	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobac	cco use contribute to the cause of death?
ord	en sig		Congestine Heart Failure		1 🗌 Yes	2 Probably 4 ☐Unknown
Records,	law ranga be	Completed	Diabeles		24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
		Con			performe	d? death? No 1 ☐ Yes 2 ☐ No
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Other	th Check onl one	
Ö	Physi r this o	. To	1 ☐ Yes 2 ☑ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 27. Manner of Death 28a. Date of Injury 28b. Time	att 3 DOA 4 I Nuising Ho	ome 5 Aesidenc 28d. Describe how	
o	nding F tth. :: After e funer	ation	1 Patural 5 Pending (Month, Day Year) Injury 2 Accident investigation	Work? M 1 ☐ Yes 2 ☐ No		
Division of	al or Attendi safter death. I Director; A d in by the fu	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (Stree City or Town, S	et and Number or Rural Route Number,
5	spital or ours aft leral Dii filled in	Cer				
	Hos Hos	Medical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, deal call Exeminer: On the basis of examination and/or and manner stated.	th occurred at the time, date and place, nvestigation, in my opinion, death occur	and due to the caus red at the time, date	se(s) and manner as stated. and place, and due to the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month, Day, Year)
			· / Weil Hellager MD	D16823	4	-4-05
1	5+1		30. Name and address of person who completed cause of death (item 23a) (Type	,		
	JT   Sta	10	Robert Schlager, M.D., 110 Hospital 31. Date filed (Month, Day, Year) 32. Registre's Signature		. Frederic	ck, MD 20678
	Registr	_	31. Date filed (Month, Day, Year)  APR 0 5 2005	Goods!		

			For State Registrar	State of M	aryland / Dep	artment of F		•	giene Reg. No. 0	5 13617
			Decedent's Name (First, Middle	Vie, Last)				2. Date of De		3. Time of Death
	Physici			Joseph Do	nald Hill			April	16, 2005	7:15 P <sub>M</sub>
	/Medic Examir		4a. Facility Name (If not institution			4b. City, Town, o	r Location of De		4c. County of	f Death
	LAGIIII		24260 Victory	Lane		Clement	s		Saint	Mary's
	Funeral		5. Social Security Number	6. Sex 7. Ag	ge (In yrs. last birthday		If Under 24 h	Hrs. 8. Date of Bir Min. (Month, Da		Birthplace (State or Foreign Country)
	Director		216-40-6272	1⊠M 2□F	63 Yrs.	Months Days	Hours IV	February	25,1942	Maryland
	pu *		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or L	ocation				10d Inside City Links
	sho	7	Tou. State		Too. Oily, Town of E	ocation				10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	the A	Director	Maryland Saint  10e. Street and Number	Mary's	Chaptico	10f. Zip Code			10g. Citizen of Wh	
:	with									iat Country !
	leath	Funeral	36876 Manor Road	12. Was Decedent	Ever in U.S. 13.	Was Decedent of H		? (Specify Yes or No	USA - 14. Race -	- American Indian.
	rtter c	표	1 Never Married 2 Mar	Armed Forces?				? (Specify Yes or No uerto Rican, etc.)	Black,	White, etc.
င္က	ours a	b	3 ☐ Widowed 4 ₺\Divorced	If Yes, Give 'Year or Dates:		1 ☐ Yes 2 ☒ No	Specify:		Specify:	White
21215-0036	tiled within 72 hours after death with the Maryland Hygione. ther than "naturel", or fems 23a or 28a-f show int, the Medical Exeminal mills of colling a	Completed	15. Deceder	nt's Education est grade completed)	16a. Dece	edent's Usual Occup	ation	working	16b. Kind of Busi	ness/Industry
2	ithin e. Mer	npl	Elementary/Secondary (0-12)	College (1-4or	life.	DO NOT use retired	1)			
2	lygier her th	Ö	7	( 1)	Car	penter	40.14.4		Construct	
Juc I	<b>6</b> g g 8	Be	17. Father's Name (First, Middle,	Last)				Name (First, Middle,		,
څ	2 should be filed within 72 hours after death with the Marylan and Mental Hygiene. and Mental Hygiene is marked other than "naturel; or frems 23a or 28a-f show eumatic event, the Medical Examana must be notified at	2	Lewis Lorenza Hil  19a. Informant's Name/Relations		10h Mail	- Add (C)		Elizabeth Gr		T. O. J.
	d 2 s th an th an treur							r Rural Route Numbe		are, Zip Code)
	ges 1 and 2 should t of Health and Men If item 27 is marke or other treumatic		Deborah Ann Nelso  20a. Method of Disposition	n / Sister	20b. Place of Disp	osition (Name of		ryland 2062 Date	20c. Location - C	ity or Town, State
٥	Pages nent of int: If it		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		į .	matory or other place	! .	April		
altimore,	permit. Pages Department of Importent: If it any injury or c	1	21 Signature of Funeral Service		2	norial Garde 2. Name and Addre	ss of Facility	20, 2005		vn, Maryland
ä	Dep per per per per per per per per per p		Michaelk	Fardiner				Tuneral Home Itown, Maryla		
	- 0		23a. Part . Enter the disease of shock, or heart failure. List	r complications that caused	d the death. Do not en					Approximate Interval Between
	กงร์เรเลก		Immediate Cause (Final			1 0 11 1	0			Onset and Death
	/Medical		disease or condition resulting in death)		tatic Smal. a consequence of):	r cerr ru	ng Canc	er		l_Month
	Examiner		Sequentially list conditions	b						
	9 %	iner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury	Due to (or as	a consequence of):					
	and and trans	Examiner	that initiated events resulting in death) Last	c.	a consequence of):					
760,	death certificate be executed eattending physician and of for use as the burial-transit	Ical E	,	Due to (or as	a consequence oi).					
68/	phys the			d.						
ŏ	eath cerlific attending p	/We	IF FEMALE:	23c. If yes, outcome	of pregnancy				23d. Date	of delivery
Ď į	atter for u	clar	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 4 ☐ Pregnant at		□Ectopic pregnancy □ Other (specify)			Month	
o l	by the detached	Physician/Med	9 Unknown	9□ Unknown						
ر. ح	iaw requires that the as been signed by th 2 should be detache	by P	Part II. Other significant condition	ons contributing to death b	out not resulting in the t	ınderlying cause gıv	en in Part I.	23e. Did to	bacco use contrib	ute to the cause of death?
ë	equire en sig	eted t						1 🕅 🗎	′es 2 ☐ No 3	Probably 4 Unknown
ecords,	aw re as be	plet						24a. Was		ere autopsy findings available or to completion of cause of
ř,	The ate his page	Compl						oheq	rmed? dea	ath?  Yes 2 No
Vital	certificate rector, pag	Be (	25. Was case referred to medica examiner?				26. Place of D	Death (Check only o		
0	Pnysi this c al dire	၉	1 ☐ Yes 2 🙀 No	Hospital: 1 Inpatie		16-5	4 U Nursin	g Home 5 ☐ Resid		represente
ב ו	fter fter ine	lon:	27. Manner of Death  1 X Natural 5 Pendir		y Year) 28b. Time o Injury	Wor		28d. Describe h	ow injury occurred	
SIC	death. ctor: A y the fu	icat	3 ☐ Suicide 6 ☐ Could		ury - At home, farm, st		Yes 2 □ No	29f Location (6	Stroot and Alumbar	or Dum I Bouto Number
	or A after of Direction by	ertification;	4 ☐ Homicide determ	nined 289. Flace of Inj	c. (Specify)	геет, тастогу, <i>о</i> птсе		City or Tox	n, State)	or Rural Route Number,
_	Hospitel 4 hours a Funerel [ tely filled	0	29a. Certifier 1 🛛 Certifyin	ng Physician: To the best	of my knowledge, deal	th occurred at the tin	ne date and pla	ace, and due to the	Cause(s) and mann	ner as stated
:	e Hoo 24 h e Fur letely	edical	(Check only 2 Medical one)	Examiner: On the basis o and manner sta	f examination and/or in	vestigation, in my o	pinion, death of	ccurred at the time,	date and place, and	d due to the cause(s)
:	To the Hospitel of Attendation 24 hours after death To the Funerel Director: completely filled in by the	Me	29b. Signature and title of certifie	ər		29c. Licensi	e number		29d. Date signed (i	Month, Day, Year)
ľ	COM.		) as a			D5068	36		April 18,	2005
•	Sh		30. Name and address of person	who completed cause of c	death (Item 23a) (Type					
			Gurdeep S. Chhabr.	a, M.D. 25500	Point Lookout	Road, Leon	ardtown,	Maryland 20	0650	
	Sta		31. Date filed (Month, Day, Year)	1 8 2005 Reg	ar's Signature	Buck				
	Registr	ar	AL IV							

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Month **Physician** - 09 - 2005 CHESTER 10:35 PM /Medical 4b. City, Town, or Location of Death 4a Fecility Neme (If not institution, give street end number) 4c. County of Death Examiner RICHARDSON STREET 7297 WILLARDS WICOMICO If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. lest birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Yeer) Birthplace (State or Foreign Country) **Funeral** Days Hours 1XM 2□ F Yrs. 87 Director 222-01-5797 12-25-1917 DELAWARE Usuel Residence of Decedent permit. Peges 1 end 2 should be filed within 72 hours efter deeth with the Meryland Depertment of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumetic event, it a Medical Examinal must be notified at 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show tre Medical Examiner must be notified at 1 X Yes 2 □ No MARYLAND WICOMICO Director WILLARDS 10f. Zip Code 10g. Citizen of Whet Country? 10e, Street end Number 7297 RICHARDSON ST. 21814 UNITED STATES Funeral . Wes Decedent Ever in U,S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Yeer or Dates: WW II Race - American Indian, Black, White, etc. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Merried Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: WHITE þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementery/Secondary (0-12) AGRICULTURE POULTRY FARMER 9 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be CHARLES HALL RUTH BRADFORD 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7297 RICHARDSON ST., WILLARDS, MD 21814 HILDA ESHAM HALL (WIFE) 20b. Place of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremetion 3 ☐ Removal from State REDMEN'S CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) 04-13-05 SELBYVILLE, DE 21. Signature of Funeral Service Licensee 22. Name and Address of Facility WATSON FUNERAL HOME, INC. Lichard SELBYVILLE, DE 19975 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Physician/Medical Examiner a ONON The lew requires that the deeth certificate be executed ettending physicien end i for use es the burial-trensit Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobasco use contribute to the cause of death? been signed by the should be detached 1. Tes 2 □ No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of deeth? Completed 24a. Was an autopsy performed? After this certificate has funeral director, page 2 1 Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Wes case referred to medicat examiner? Be 26. Place of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 2 1 Yes 2 No Residence 6 Other (Specify) 28e. Date of Injury (Month, Dey Year) Certification: 27. Menner of Deeth 28b. Time of 28c 28d. Describe how injury occurred Injury et Work? 1. Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No deeth. nours efter deeth.
ners! Director: A
filled in by the fu 2 Accident 6 Could not be determined 3 🗌 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital of within 24 hours of To the Funeral Discompletely filled is 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as steted. edicai 2 Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, death occurred et the time, date end place, end due to the cause(s) end manner steted. 2 29b. Signature and title of o 29c. License number 29d. Date signed (Month, Dey, Yeer) rtifie Ylvilo NC952000

State

Registrar

00 31. Dete filed (Month, Day, Year APR 1 1 2005

1346 Si Nivisin 1t, 32. Pagistrar's Signeture

completed cause of deeth (Item 23e) (Type, Print)

Salulany, and 21804

**DHMH 16 Rev 6/95** 

ORIGINAL

	1 - State Registrar	Tent Ministr 4	antl		Cert	tificate of	Death	2. Date of De	giene Reg. No.	2005	3. Time of Death
an	Decedent's Name (Fi							Month	Day		
cal	Richard  4a. Facility Name (If not		Hilliard			4h City Town o	or Location of Dea	April	06	2005 County of Death	06:19ª
ner		_				Chever				ince G	
-	Prince Geo  5. Social Security Number		Sex 7. Age	e (In yrs. last b	birthday)	If Under 1 Year	If Under 24 Hi		th		optace (State or Foreig
	579-64-295		1 <b>⊠</b> M 2□F	56	Yrs.	Months Days	Hours Mi	June 2	24,1	948 Sou	th Carol
	Usual Residence of Dec	cedent b. County		10c. City, To	own or Loc	ation					10d. Inside City Limit
ō	DC	,		Washi							1 ☐ Yes 21X N
rect	10e. Street and Number	ır		Wasiii	inge	10f. Zip Code			10g. Citi	zen of What Cou	untry?
Funeral Director	1006 49th	h Plac	ce N.E.			20019			USA		
ner	11. Marital Status		12. Was Decedent I Armed Forces?	Ever in U.S.	13. W	/as Decedent of I	lispanic Origin?	(Specify Yes or No arto Rican, etc.)	>-	14. Race - Amer Black, White	
Fu	1 Never Married		1 XYes 2 N If Yes, Give	40	i	☐ Yes 2X No	Specify:	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			
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0	17. Father's Name (Firs			110	abor	CT	18. Mother's N	ame (First, Middle			icing off
108	George Ja	ackso	n				Bernio	ce Hill	iard	1	
_	19a. Informant's Name			19	9b. Mailing	Address (Street		Rural Route Numb			ip Code)
	Rosa Hill:		(Wife)				lace NI	E. Wash,			
	20a. Method of Disposit	ition	☐Removal from State	20b. Place cemet	of Dispos	ition (Name of atory or other pla	се)	Date	20c. Lo	cation - City or 1	Town, State
	'4 Donation 5	remation 3 ☐ Other (Spec	cify)	Fort	Lin	coln	Apr	112,05	Bren	twood.	Md.
	21. Signature of Funer	Service Lic	ensee		22.	Name and Addre					
	spor	e 1	- suu	ng						dy St.	NW 2001
	23a. Part   Biter the d shock, r heart fa	diseas or co ailure. List on	mp ic stion, that caused ly one cau e on each lir	ne.				ac or respiratory a	rrest,		Approximate Interval Between Onset and Death
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			11100011	1 1 1 1	ce of):						
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DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For Stete Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death-Day **Physician** Month Marjorie Morgan Horvath /Medical April 2:10 PM 2005 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Genesis HealthCare -The Pines Easton Talbot 8. Date of Birth Sept. 2, 1946 Delaware If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Hours 1 ■ M 2 🖼 Days 58 189-40-6063 Director Usual Residence of Decedent 10a State 10h Count 10c. City, Town or Location item 27 is marked other then "natural", or items 23a or 28e-f show other treumatic event, the Medical Examinar must be notified at 10d. Inside City Limits Director Maryland Queen Anne Centreville 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 304 Queen Anne Circle, Funeral Apt. D 1 21617 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 o o o f Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ρ 1 Yes 2 No Specify Specify. 3 Widowed 4 Drivorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 should be filed within 7 in and Mental Hygiene. 7 Is marked other then "n Elementary/Secondary (0-12) College (1-4or 5+) 10 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be David J. Morgan Jean Lawrence 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 I Deborah Stottlemyer/Sister P.O. Box 760, Stevensville, MD 21666 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages Department of Importent: If it any injury or o ō 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fairview Cemetery 4/15/2005 Boyertown, PA Name and Address of Facility 1d Shore Cremation Center, 272 Hudson Rd., Cambridge, 21. Sign to e of Funeral Service Licensee 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart latitude. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** failure\_ weaks disease or condition resulting in death) /Medical Examiner gomyelia Sequentially list conditions, Examiner if any leading to immedicause. Enter Underlying Cause (Disease or injury as a consequence of) The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy ō in the past 12 months? Month Dav Year 4 Pregnant at time of death 5 ☐ Other (specify) P.O. | 1 ☐ Yes 2 ☐ No the 9 Unknown 9 Unknown Š Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Nnknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 Yes 25 No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death Check onl one examiner Other: 4 Chursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes ₹ No Certification: To 1 | Inpatient 2 ER/Outpatient 3□ DOA this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation after death Director: 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) à within 24 hours after
To the Funeral Direc 4 Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 610 1) OTCHMANS Registrar's Signature State Registrar

DHMH 17 Rev 1/200

Marjorie Horvath

		1 - For State Registrar  1. Decedent's Name (First, Middle,	Last)		rtificate of Death	2. Date of Death	3.110.2	1367 Time of Death
Physici		Pearl Ray				Month	Day Year	
/Medio		4a. Facility Name (If not institution,			4b. City, Town, or Location of D		4c. County of Death	2100
		Dorchester Ge	neral Hospit	al	Cambridge		Dorchester	
Funeral			5. Sex 7. Age 1	(In yrs. last birthday,		Hrs. 8. Date of Birth (Month, Day, )		
Director		220-10-6619 Usual Residence of Decedent		92 115.		Aug. 24	, 1912 Maryl	and
ims 23a or 28a-f ahow Friust be fieldfied at		10a. State 10b. County		10c. City, Town or L			10d. Ir	nside City Lim
8a-1a	cto	MD Dorc	hester		Cambridge	2	1	XYes 2□
nt of Health and Mental Hyglene. If Itam 27 is marked other than "natural", or Itams 23a or 28a-1 ahow or other traumatic avant, the Medical Examinations is a calified at	by Funeral Director	10e. Street and Number			10f. Zip Code	100	g. Citizen of What Country?	
ns 23g	eral	425 Henry Stree	12. Was Decedent E	verin II S 13	21613	2 (Specify Ven or No	USA 14. Race - American Inc	dian
rltan	Fun	1 Never Married 2 Married	Armed Forces?	0	Was Decedent of Hispanic Origin' If Yes, specify Cuban, Mexican, Po	uerto Rican, etc.)	Black, White, etc.	uan,
ral', o	l by	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 ☑ No Specify:		Specify: white	
lical	Completed	15. Decedent's (Specify only highest		16a. Dece	edent's Usual Occupation	working 16	Sb. Kind of Business/Industry	,
han i	Idm	Elementary/Secondary (0-12)	College (1-4or 5-	·life.	e kind of work done during most of DO NOT use retired)	1		
al Hygiene. I othar than " vant, I'ls Me	ပိ	17. Father's Name (First, Middle, La	est)		machine operato	DY Name (First, Middle, Ma	garment	
ental kado cava	To Be	John Henry	,			ata Hurley	ilder Samarie)	
and Menis marka	F	19a. Informant's Name/Relationship	o (Type, Print)	19b. Maili	ing Address (Street and Number of		City or Town, State, Zip Code	e)
tam 27 is		Dorothy Lee Barr	row daugh		6 Mount Holly Ro			21631
of He litam rothe		20a. Method of Disposition		20b. Place of Dispo	osition (Name of matory or other place)		c. Location - City or Town, S	
ment of land: If its		1  Burial 2  Cremation 3			Market Cemetery	4/9/05 E	East New Marke	≥t. Mr
Department of Health Important: If itam 27 any injury or othar tr once.		21. Signature of Funeral Service Lic				The second secon	eral Home P.A.	
으트 eg ol		Drunk. D	int		700 Locust St.,			
		23a. Part1. Enter the disease, or co shock, or heart failure. List or	omplications that caused to try one cause on each line	the death. Do not en	ter the mode of dying, such as care	diac or respiratory arres	Inter	oximate val Between et and Death
sician ledical		Immediate Cause (Final disease or condition resulting in death)	a. bowel	obstructio	on		Onse	st and Death
aminer		1		consequence of):				
	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin, Cause (Disease or injury	D	cancer consequence of):				
ansit	Examiner	Cause (Disease or injury that initiated events	c					
an an irial-tr	Exa	resulting in death) Last	Due to (or as a	consequence of):				
hysici he bu	lcal		d					
ed by the attending physician and detached for use as the burial-transit	Physician/Med	IF FEMALE:						
attend tor us	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome o	Fetal death 3	Ectopic pregnancy		23d. Date of delivery Month Day	Year
the ched	ysic	1 ☐ Yes 2 🗷 No 9 ☐ Unknown	4∐Pregnant at t 9⊡ Unknown	ime of death 5	Other (specify)			7 541
ed by deta	/Ph	Part II. Other significant conditions	s contributing to death but	not resulting in the u	inderlying cause given in Part I.	23e. Did tobac	cco use contribute to the cau	se of death?
pe g	٥	dementia - Alzh				1 ☐ Yes	2⊠No 3 Probably	4 Unknov
should	Completed	osteoperosis				24a. Was an	24b. Were autopsy fir	ndings availal
ate has page 2	omp		· · · · · · · · · · · · · · · · · · ·			<ul> <li>autopsy performe</li> </ul>	prior to completion death?	on of cause of
certificate rector, pag	Be C	25. Was case referred to medical			26 Place of I	1 ☐ Yes 2 2 Death (Check only one)	No 1 ☐ Yes 2 ☐ N	10
g ip	To B	examiner? 1 □ Yes 2 🗷 No	Hospital:	t 2 EP/Outpatier	0.0	g Home 5 Residence	ce 6 □Other (Specify)	
ter th		27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 28b. Time of Injury		28d. Describe how		
tor: Afr the fur	catlo	2 ☐ Accident investigat	ion		M 1 ☐ Yes 2 ☐ No			
Diractor: in by the	Certification:	3 ☐ Suicide 6 ☐ Could not determine		y - At home, farm, str (Specify)	reet, factory, office	28f. Location (Stree City or Town, S	et and Number or Rural Rout State)	e Number,
T pe						li li		
m =	lica	29a. Certifier 1 Certifying 1 (Check only one) 2 Medical Ex	enysician: To the best of aminer: On the basis of and manner state	examination and/or in	h occurred at the time, date and pla vestigation, in my opinion, death of	ace, and due to the caus ccurred at the time, date	se(s) and manner as stated. and place, and due to the c	ause(s)
Funaral			and manner state	su.	29c. License number	29d.	. Date signed (Month, Day, Y	(ear)
To the Funeral completely tilled	Medical	29b. Signature and title of certifier						
To the Funeral Direc completely tilled in by	Mec	29b. Signature and title of certifier		Mn	D 57290		4/4/05	<i>-</i>

State of Maryland / Department of Health and Mental Hygiene

			1 - State Registrar	,	Ce	rtificate of L	Death		Reg. No.		
	<b>D</b> I		1. Decedent's Name (First, Middle, L.	ast)				2. Date of D	eath 1	Vaar	3. Time of Death
	Physici /Medi		Richard	Bradford	H	Iardesty	•	April	5 20	005 <sup>ear</sup>	1:30 р-м
	Examir		4a. Facility Name (If not institution, gi Washington Advent			4b. City, Town, or Takoma Pa	Location of Deatl	ר		ty of Death	rv
	Funeral		Social Security Number 6.		s. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of B (Month, D Jan 4,	irth	9. Birth	place (State or Foreign
	Director		Usual Residence of Decedent	11 - 00	113.			pair 4,	1925	Mary	yland
	be filed within 72 hours after death with the Maryland tal Hygiene. Id other than "natural", or items 23a or 28a-1 show ovent, it e Medical Evarities in the life of the state ovent.	o	MD Anne Arr		City, Town or Lo	ocation Lothia	an			1	10d. Inside City Limits 1 ☐ Yes 2 X No
	the 28a	rect	10e. Street and Number			10f. Zip Code			10g. Citizen o	of What Cour	ntry?
	h with	al Di	69 Patuxent Mob	ile Estates		20711			US	A	
	items	Funeral Director	11. Maritat Status 1 □ Never Married 2 ☑ Married	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (S n, Mexican, Puert	pecify Yes or N o Rican, etc.)	0- 14. R	ace - Americ lack, White,	
036	rai', or	þ	3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ No If Yes, Give A Year or Dates:		1 ☐ Yes 2X No	Specify:		Spec	oify: whi	ite
5	"natu	letec	15. Decedent's E (Specify only highest g.		16a. Dece (Give	dent's Usual Occupa kind of work done of DO NOT use retired	ation during most of wor	king	16b. Kind of	Business/In	dustry
21215-0036	should be filed withir nd Mental Hygiene. marked other than matic event, its Ma	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		y eqipmen			waste	and re	efuse
	oe filed al Hygid d other	Bec	17. Father's Name (First, Middle, Las				18. Mother's Nar	ne (First, Middle	e, Maiden Sum		
Maryland	should be t ind Mental b marked of umatic eve	10	Benjamin	Hardest		Add (C44	Mary		O't T		eay
			19a. Informant's Name/Relationship Thelma M. Hardes:		1	ng Address <i>(Street a</i> atuxent Mo					20711
ore,			20a. Method of Disposition  1 X Burial 2 □ Cremation 3		Place of Dispo cemetery, cre	osition (Name of matory or other place	е)	Date	20c. Location	n - City or To	own, State
altimore,	Pa Int		`4 □ Donation 5 □ Other (Spec	ify) Tr		Cemetery		9–2005	Upper	Marlb	oro, MD
Ba	permit. Pa Departmer important any injury once.		21. Signature of Funeral Service Lice	onsee Car		<ol> <li>Name and Address</li> <li>ausch Fun</li> </ol>		e. P.A.	, Owin	as.	MD 20736
			23a. Part1. Enter the disease, or cor shock, or heart failure. List only	nplications that caused the de					·	J- 7	Approximate Interval Between
	Physician:	ı V	Immediate Cause (Final disease or condition	Call	duac	Cuu	uthme	2			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conse	equence of):		1				
		ř	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that in the lead are or injury	b. Due to (or as a conse	quence of):	aum					
	acuted ind transit	Examine	Cause (Disease or injury that initiated events resulting in death) Last	c							
60,	ertificate be executed ling physician and e as the burial-transit		resulting in death, cast	Due to (or as a conse	equence of):					:	
68760,	ificate g phys as the	Medical		_ d							
Вох	th cert tendin or use	~	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe	nancy tal death 3[	□Ectopic pregnancy				Date of delive	
о. П	The law requires that the death certificate be executed tie has been signed by the attending physician and hage 2 should be detached for use as the burial-transit	Physician	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of 9□Unknown	death 5[	Other (specify)				VIOLITI	Day Year
<u>α</u>	es that igned by be deta	by Pr	Part II. Other significant conditions	contributing to death but not re	sulting in the L	anderlying cause give	en in Part I.	23e. Did	tobacco use co	ntribute to t	he cause of death?
Vital Records,	w require been sig should t	ted	_ Cormaly	Clifly C	llxa	N		1 🗆	Yes 2□No	3 Prob	pably 4 Munknown
3ec	e law has b je 2 st	Completed	- Renal	Jellu	и			24a. Wa	s an 24b opsy formed?	prior to co death?	psy findings available impletion of cause of
la		e Co	25. Was case referred medical	<u> </u>			26. Place of Dea	1 Yes	2 🗆 No	1 ☐ Yes	2. No
Ž	Physician: this certifican al director,	To B	examiner? 1 Tes 2 No	Hospital: 1 Inpatient 2	☐ ER/Outpatie	nt 3 DOA Othe	ar		sidence 6 C	ther (Specif	(y)
n of	a = a		27. Mann of Death 1 Matural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Worl	k?	28d. Describe	how injury occ	urred	
Division	Attending in death. ector: After by the fune	ficati	2 Accident investigation 3 Suicide 6 Could not	be One Blace of Injury At	home, farm, st		Yes 2 □ No	28f. Location	(Street and Nur	mber or Rura	al Route Number,
<u>≥</u>	s after s after bit bit b	Certification;	4 Homicide determine	building, etc. (Spec	cify)	,,,		City or To	òwn, State)		
	To the Hospital or Attenc within 24 hours after death To the Funeral Director: completely filled in by the	Medical (	29a. Certifier 1 Certifying F (Chedronly 2 Medical Exa	hysician: To the best of my kilominer: On the basis of examinand manner stated.	nowledge, deal nation and/or in	th occurred at the time envestigation, in my of	ne, date and place pinion, death occu	, and due to the irred at the time	e cause(s) and i	manner as s e, and due to	tated. the cause(s)
1	To the within To the comp	Me	29b. Signature and title of certifier			29c. License	number	7	29d. Date sign	ned (Month,	Day, Year)
•			00 November 1	a completed assume of death "	am 22=1 /** -	Drint)	014/		41	6/0	1
	ID.		30. Name an address of person who Dr. Nasreen Kar			.Print) re., Takom	a Park,	MD 209	12	70	
	Sta		31. Date filed (Month, Day, Year)	32. Registras Sig	nature				_		
	Regist	rar	APR	8 2005 Blace	is St	Dones					

			1 - For State Registrar	State of N	1arylan		artment of				giene Jeg. No.	005	136	524
	Physici /Medic		1. Decedent's Name (First, Middle, L $Eva$	ast)	Hawk	kins				Date of Dea Month pril		005 <sup>Year</sup>	3. Time of 0 5 3 5	Death M
	Examir	ner	4a. Facility Name (If not institution, g. Calvert Memo	rial Hos	pital		4b. City, Town	e Fred	deric			Calv	ert	
	Funeral Director		5. Social Security Number 214-76-9775  Usual Residence of Decedent	Sex 1 □ M 2 ▼ F	78	last birthday) Yrs.	If Under 1 Ye Months Day		Min. A	Date of Birth (Month Day pr. 13	1°92	6 Mar	pplace (State or intry) yland	r Foreign
	e Maryland 8e-f show lifted at	ctor	10a. State 10b. County	vert	10c. City	y, Town or Lo		kirk					10d. Inside City	
	ath with the 23e or 21	ral Director	3401 Lyons C					0754			U	of What Cou S A	intry?	
980	72 hours after death with the Maryland netural', or Itams 23e or 28e-f show deal Examinet must be notified at	by Funeral	11. Marital Status  1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Deceder Armed Forces 1  Yes 2  If Yes, Give Year or Dates	χNο		Was Decedent of Yes, specify C			fy Yes or No- can, etc.)	1	Race - Ameri Black, White pecify: B1 a	, etc.	
Maryland 21215-0036	within ene. than "	Completed	15. Decedent's I (Specify only highest g		· 5+)	(Give	dent's Usual Ockind of work do NOT use rei	ne during mos tired)	st of working		16b. Kind	of Business/Ir	ndustry	
land	ould be filed Mental Hygi harked other hatic avant,	To Be C	17. Father's Name (First, Middle, Las Ernest	-	wkins	5		18. Moth E13		First, Middle,		mame) awling	gs	
	d 2 should the and 7 is mettraum		19a. Informant's Name/Relationship Rosie Hill/ni	(Туре, Print) есе		19b. Mailir P.O.	Box	eet and Numb 444 I	er or Rural F Dunki	rk, M	r, City or To	own, State, Zij 754	p Code)	
Baltimore,	mit. Pages 1 an partment of Heall ortant: If itam 2 Injury or other 8.		20a. Method of Disposition  1  Burial 2  Cremation 3  4  Donation 5 Other (Special Control Con		20b. P	emetery, crer per 's	sition (Name of natory or other p S UMC (	Cem.		005	Dunk	ion - City or T irk, l	MD	
Balt	permit. Page Department Important; If any Injury o		21. Signature of Funeral Service Lice Plady a.	Sewell	2		Name and Add					al Hor Fred	ne ,MD 2	.0678
	Physician /Medical Examiner	Examiner	23a. Part1. Enter the disease, or corshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	a. Die to (or a Due to (or a Du	s a consequence s a consequence	nellity Jence of): Jins Jence of):	s typ	ieny	cardiac or r	espiratory arr	est,	5	Approximate Interval Betwoonset and D Thurs Several	veen
68760,	icate be executed physician and s the burial-transit	cal	resulting in death) Last	Due to (*) a	s a consequ	uence of):	Retard	lation					all li	fe .
.O. Box	that the death certifics ed by the attending pt detached for use as t	Physician/Medi	IF FEMALE: 23b, Was decedent pregnant in the past 12 months? 1 □ Yes 2 ₩ O 9 □ Unknown	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 🗌 Fetal	death 3	Ectopic pregna Other (specify)				23d.	Date of delive	,	ear
ords, P	w requires that been signed be should be det	by	Part II. Other significant conditions	contributing to death	but not resu	ulting in the ur	nderlying cause	given in Part I		23e. Did tol			the cause of de	
Vital Record	The law ate has b page 2 st	e Completed	25. Was case referred to medical								ned?	4b. Were auto prior to co death? 1 \( \sum \text{Yes} \)	opsy findings at ompletion of car 2 No	valiable use of
of	Phys this ral dir	ToB	examiner?  1 Yes 2 No  27. Manner of Death	Hospital: 1 Impat	ury	ER/Outpatien	3 DOA	Other: 4 Nu	ırsing Home	5 Reside	ence 6 🗆	Other (Specif	fy)	
Division	To the Hospitel or Attanding Phywithin 24 hours after death. To tha Funarel Director: After thi completely filled in by the funeral.	ertification:	1 Natural 5 Pending 2 Accident investigatio 3 Suicide 6 Could not 4 Homicide determined	28e. Place of Ir		Injury me, farm, stre		Yes 2	No		reet and N		al Route Numb	per,
	e Hospitel or 124 hours afte a Funarel Dir letely filled in I	edical C	29a. Certifier 1 Certifying P (Check only one) 2 Madical Exa	hysician: To the bes minar: On the basis and manner s	of examinat	wledge, death ion and/or inv	occurred at the restigation, in m	time, date an y opinion, dea	nd place, and oth occurred	due to the ca at the time, da	ause(s) and ate and pla	d manner as s ce, and due to	itated. o the cause(s)	
)	To the l within 2 To tha l complet	Me	29b. Signature and title of certifier	HOSPITA	LIST			onse number	o	2	9d. Date si	gned (Month,	Day, Year)	
Ó	?		30. Name and address of person who ADEEB JABE	0 100	Hose	ITAL	RO.	PRIN	ice F	REDER	.(CIC	mo	2067	ક
	Sta Registr		31. Date filed (Month, Day, Year)	32. Regis	Irags Signat	, K	Coule	20						

	IX.		1- For State of Maryland / Department of Health a Certificate of Death	and Mental H	6	- G U U D	13625
			Decedent's Name (First, Middle, Last)	2. Date of	Reg. No Death	) <u>.</u>	3. Time of Death
	Physici		Theda O. Henle	Month	Da	Year Year	0835 M
	/Medio Examin		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location or	of Death		: County of Death	0833
	LXamii		Prince George's Hospital Cheverly			rince 6	*****
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 2		DILLI	9. Birth	place (State or Foreign
	Director		050–18–4328 1□ M 2X F 87 Yrs. Months Days Hours	Min. (Month, 3–21	Day, Year) -1918	Cal	ifornia
	pu ,		Usual Residence of Decedent		-		
	aryla shov	-	10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
	Ba-f	Director	Maryland Prince George's Mitchellville				1 ☐ Yes 2 XNo
	with t				10g. Cit	tizen of What Cou	ntry?
	s 23	rai	10450 Lottsford Rd., Apt. 370 20721  11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Original Control Original Cont			USA	
	item item	Funerai	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Never Married  2 ☑ Married  1 □ Yes ▼☑ No  1 □ Yes ▼☑ No	n? (Specify Yes or , Puerto Rican, etc.)	No-	<ol> <li>Race - Americ Black, White,</li> </ol>	
336	urs al	by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:			Specify: Wh	nite
Ģ	2 hou	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation		16b. K	(ind of Business/In	dustry
21	hin 7	pie	(Specify only highest grade completed)  (Give kind of work done during most life. DO NOT use retired)  Elementary/Secondary (0·12)  College (1·4or 5+)	of working			,
7	giene giene	)om	4 years Writer			Arts	
힏	be filed within 72 hours after death with the Maryland ital Hyglene. d other then "natural", or items 23e or 28e-f show event. The Medical Evarial at most be redified at	Be (		r's Name (First, Mide	dle, Maiden	Sumame)	
<u> </u>	Ment Ment arked	To	Frank S. Ostrander Kat	therine E	Burnha	am	
lar	2 sho and is my		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number	r or Rural Route Nur	nber, City o	or Town, State, Zir	Code) 20721
≥.	and ealth m 27		Peter Henle/ Husband 10450 Lottsford Ro	d., Apt. 3	370, M	iitchelly	rille,MD <sup>2</sup>
ore	of H of H Miter		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State	Date	20c. Lo	ocation - City or To	own, State
Ĕ	Pag ment ent:		'4 □Donation 5 □Other (Specify) Kalas Crematory	4-5-05	_	gewater,	
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importment: If item 27 is marked other then "natural", or items 23e or 28a-f show any injury or other treumatic event. It is Medical Examiliar must be rediffied at once.		21. Signature of Euneral Service Licensee 22. Name and Address of Facility 2973 Solomons I	George F	. Kal	as Funer	ral Home
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as of			macci y 1.	Approximate
	Physician		shock, or heart failure. List only one cause on each line.  Immediate Cause (Final	0	Ho. 4	+ D ==	Interval Between Onset and Death
	/Medical		Immediate Cause (Final disease or condition resulting in death)  a. Athere sidestic Candiavis	scuar	any	1388E	<u>e</u>
	Examiner						
		ner	Sequentially list conditions, Tarry, leading to immodiate cause. Enter Undertying Cause (Disease or injury				
	cuted	Examiner	that initiated events C.				
oʻ	e exe ian a urial-t	Ä	resulting in death) Last Due to (or as a consequence of):				
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dicai	d				
9	leath certific attending p	0					_
Вох	ath ce ttend or us	Physician/M	23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy  1 Live birth 2 Fetal death 3 Ectopic pregnancy		4	23d. Date of delive Month	,
0	the a	Sic	1 Yes 2 No 9 Unknown 4 Pregnant at time of death 5 Other (specify)		-	MOIIII	Day Year
<u>G</u>	that the deled by the detached	P.	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	220 Di	d tobales u	ran contribute to th	
Š,	signe signe	þ			TYes 2	use contribute to th □ No 3 □ Prob	
O.C.	w requir been s should	eted					abiy 42 Olikilowii
Records,	e law has b	Completed		24a. Wi	topsv	prior to cor	psy findings available apletion of cause of
	: The l			pe 1 ☐ Yes	rformed?	death? 1 ☐ Yes	2□ No
Vital	ysician: Th is certificate director, pag	Be	examiner?	of Death Check onl	one		
	Phys this al dir	5	1 Inpatient 2 ER/Outpatient 3 DOA 4 Nurs	sing Home 5 Re			1)
U.	ding l h. After funer	ion	1 → Matural 5 □ Pending (Month, Day Year) Injury Work?	28d. Describ	e now injur	y occurred	
S	death. ctor: A y the fu	cal	3 ☐ Suicide 6 ☐ Could not be ago Place of Injury. At home form stoot for the stoot fo		(Stroot on	d Number or Rura	I Clauta Mumbas
Division of	l or Atten after deat Director: I in by the	Certification:	4 Homicide determined building, etc. (Specify)		own, State		i noute Number,
_	To the Hospitel or Attending Physician: within 24 hours after death. To the Funerel Director: After this certified completely filled in by the funeral director.		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and	place, and due to th	e cause(s)	and manner as st	ated.
	the Ho nin 24 the Fu pletel	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death and manner stated.	occurred at the tim	e, date and	place, and due to	the cause(s)
	To Too	~	29b. Signature and title of certifier  29c. License number			e signed (Month, i	
			Antodor Store Do Hoo5557	17	Apr	11 4,2	005
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	/		,	
			SAlvador Sylvester, 3001 Hossital Drive, Che 31. Date filed (Month, Day, Year) 32 degistrar's Signature	everly	MAR	1 ANd	
	Sta Registra		31. Date filed (Month, Day, Year)  APR 0 5 2005	V *			
	31011						

### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Month Vear **Physician** 3:30 A M William Johns, Jr. March 30, 2005 /Medical 4b. City, Town, or Location of Deeth 4a Fecility Name (If not institution, give street end number) 4c. County of Death Examiner 6845 Hopkins Neck Road Easton Talbot If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 5. Social Security Number 7. Age (In yrs. lest birthday) Birthplece (Stete or Foreign Country) **Funeral** Months 1⊠M 2□ F 81 Yrs. Sept.9, 1923 Director 215-18-4270 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health end Mantal Hygiene. Important: If item 27 ie marked other than "naturel" ~ \*\* eny injury or other traumatic even. 10a State 10b. County 10c, City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2XXNo Funeral Director Talbot Maryland Easton 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 6845 Hopkins Neck Road 21601 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 11. Maritel Status 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify. Specify: Black Be Completed by 3 ₩ Widowed 4 Divorced Year or Detes 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Calhoun Engineering Elementary/Secondery (0-12) College (1-4or 5+) Custodian School 7th 18. Mother's Name (First, Middle, Maiden Surneme) 17. Fether's Name (First, Middle, Last) William Johns, Sr. Lottie Young 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Charles Johns, son 6845 Hopkins Neck Road, Easton, Maryland 21601 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1XXBurial 2 Cremation 3 Removal from State 4/9/05 Hillsboro, Maryland Sandtown 4 ☐ Donation 5 ☐ Other (Specify) 426 Dover Street Bennie Smith Funeral Home 21. Signature of Fyneral Service Licenses 22. Name and Address of Facility Easton, Maryland 21601 e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. List only one cause on eech line. Approximate Interval Between Onset end Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) Year Examiner Due to (or as a consequence of): Examiner ettending physician end for use es the bunal-trensit or Attending Physicien: The law requires that tha death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of): Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 ☐ Probabiy 4 ☐ Unknown 1 ☐ Yes 2 ☐ No \$ 24b. Were autopsy findings available prior to completion of cause of death? after death. Director: After this certificate has been sir d in by the funeral director, pega 2 should I 24a. Wes an autopsy performed? Be Completed Mellitus Type II 1 Tyes 21. N 1 ☐ Yes 2 ☐ No pertens 25. Wes case referred to medical 26. Plece of Death (Check only one) Hospitel: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Medical Certification: To 2 ER/Outpatient 3 DOA 28e. Dete of Injury (Month, Dey Year) 27. Menner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Neturel 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide

To the Hospital or Atterview within 24 hours after deserted to the Funeral Director completaly filled in by the

State Registrar 29a. Certifier (Check only one)

29b. Signature end title of certifier

31. Date filed (Month, Pay

30. Neme end address of person who completed cause of death (Item 23a) (Type, Print)

M.D.,

legistrar's Signa

Mary S. Deshields,

Year)

**DHMH 16 Rev 6/95** 

TX Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated.

29c. License number

509 Idlewild Ave., Easton, Maryland 21601

29d. Date signed (Month, Day, Yeer)

00

			1 ← For State		and / Dep	artment of Health rtificate of Death	and Mental Hy	•	10007
			Registrar  1. Decedent's Name (First, Middle, L	ast)		runcate or Deatr	2. Date of De.	Reg. No.	10021
	Physic		Fred Kimn				Month	Day Year	
	/Medi Exami		4a. Facility Name (If not institution, g.			4b. City, Town, or Location		4c. County of Dea	
1			Peningula Legio	val Nedical	Center	Salisha		Wicon	
	Funeral		5. Social Security Number 6.	Sex 7. Age (In	rs. last birthday)	If Under 1 Year If Under Months Days Hours	Min. 8. Date of Birt		thplace (State or Foreign ountry)
	Director		292-01-1113	12M 2□F 95	Yrs.	World Days Hours	9/1/19	09 0	hio
	and and		Usual Residence of Decedent  10a. State 10b. County	10c.	City, Town or Lo	ocation			10d. Inside City Limits
	Mary f sho	jo	Maryland Wicomi		Salisb				1 Yes 2 No
	r 28e	rec	10e. Street and Number		Dailso	10f. Zip Code	· ·	10g. Citizen of What C	
	ours after death with the Marylan ral', or Items 23a or 28e-f show Ext. :iirer: sist te natified at	Funeral Director	1007 E. Schumak	er Manor Driv	re	21804		USA	
	ems deal	ner	11. Marital Status	12. Was Decedent Ever i	n U.S. 13.	Was Decedent of Hispanic Or If Yes, specify Cuban, Mexica	rigin? (Specify Yes or No-	14. Race - Am	
36	or it		1 Never Married 2 Married	1 ☐ Yes 2 ŽNo If Yes, Give	1	1  Yes 2 No Specify			white
Ö	72 hours after death with the Maryland "natural", or Items 23a or 28e-f show olical Exaciliter and be notilited at	Completed by	3 ∰Widowed 4 □ Divorced	Year or Dates:					
5	.5	olete	15. Decedent's E (Specify only highest g	ducation ade completed)	16a. Dece	dent's Usual Occupation kind of work done during mos DO NOT use retired)	st of working	16b. Kind of Business	/Industry
212	s within liene. r than "	mo	Elementary/Secondary (0-12)	College (1-4or 5+)		eral Manager		Paper Mil	l Business
b	Hyg Tr	a)	17. Father's Name (First, Middle, Las	t)	COLL		er's Name (First, Middle,	Maiden Surname)	
/lar		ToB	Nevin Edward Kim	mel		Bla	nche Anna W	eavor	
Maryland 21215-0036	2 should and Men is marke aumatic		19a. Informant's Name/Relationship	(Type, Print)	19b. Mailir	ng Address (Street and Numb			Zip Code)
Σ,	1 and 2 Health am 27		Dr. Kent N. Kim	mel/son	1121	Riden Court,	Salisbury.	MD 21804	
ore	iges 1 and 2 should tof Health and Mer if itam 27 is marke or other traumatic		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 [		<ol> <li>Place of Dispo</li> </ol>	sition (Name of matory or other place)	Date	20c. Location - City or	Town, State
Ë	tment tant:		`4 ☐ Donation 5 ☐ Other (Spec	fy) S		ove Cemetery	4/14/2005	W. Alexandı	cia, OH
Baltimore,	permit. Pages 1 an Department of Heal Important: If itam 2 any injury or other	(	21. Signature of Funeral Service Lice	nsee	22 H	Name and Address of Facility Olloway Funer	al Home Pro	fessional A	Association
	402 4 1		23a. Part1. Enter the disease, or con	growdness	2101	O I DITOM TITTT	ru. Saliso	urv. MD 218	304
			shock, or heart failure. List only	one cause on each line.		er the mode of dying, such as	cardiac or respiratory ari	rest,	Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Freu,	rinon				2 WKJ
	Examiner			Due to (or as a cons	sequence or):				
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a cons	equence of):				
	rcuted	Examiner	that initiated events	C					
8760,	cate be executed physician and the burial-transit		resulting in death) Last	Due to (or as a cons	sequence of):				
	cate t	dlcal	•	d					
9 X	that the death certific; ed by the attending pl detached for use as t	Physiclan/Med	IF FEMALE:	23c. If yes, outcome of pre-	ananov.				
Вох	atten for u	clan	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 □ F	etal death 3	Ectopic pregnancy Other (specify)		23d. Date of del Month	ivery Day Year
<u>о</u> .	at the de by the tached	ıysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	death 5	Other (specify)			
	The law requires that the the has been signed by thoage 2 should be detached.	by PI	Part II. Other significant conditions	contributing to death but not	esulting in the ur	nderlying cause given in Part I	. 23e. Did to	bacco use contribute to	the cause of death?
ğ	w require been sig should b						1Y	9S 2 <b>□ H</b> 6 3 □ Pr	obably 4 Unknown
င္တ	aw requisite been 2 should	Completed					24a. Was a		topsy findings available
æ	The lavite has	mo					autops	med? prior to death?	completion of cause of
ta	itan: ortifica ctor, p	BeC	25. Was case referred to medical examiner?			26. Place	1 ☐ Yes		2 No
<u> </u>	Attending Physician: r death. actor: After this certifice by the funeral director.	2	1 Yes 2 Ho	Hospital: 1 Inpatient 2	☐ ER/Outpatien	O+	rsing Home 5 Reside		cify)
u u	Ing P	on:	27. Manner of Death  1 ■ Natural 5 ■ Pending	28a. Date of Injury (Month, Day Year,	28b. Time of Injury	28c. Injury at Work?	28d. Describe ho	ow injury occurred	
Sio	death death stor: A the fu	cati	2 Accident investigation 3 Suicide 6 Could not be			M 1 Yes 2	No		
Division of Vital Records,	after of Dirac	ertification:	4 Homicide determined		home, farm, stre cify)	eet, factory, office	28f. Location (St City or Town	reet and Number or Ru n, State)	ral Route Number,
	ospitel hours a unaral I ly filled	O	29a. Certifier 1 Certifying Pl	vsician: To the best of my	nowledge dooth	occurred at the time, date an	d place and due to the	2007(2) 4 - 1 - 1	
	To the Hospitel or Attending Physician: The within 24 Hours after death.  To tha Funaral Diractor: After this certificate ha completely filled in by the funeral director, page	Medical	(Check only 2 Medical Example)	niner: On the basis of exami and manner stated.	nation and/or inv	estigation, in my opinion, dea	th occurred at the time, do	ause(s) and manner as ate and place, and due	stated. to the cause(s)
	Io the Ho within 24 To tha Fu completel	Me	29b. Signature and title of certifier	<i>f</i> 1		29c. License number	2	9d. Date signed (Month	, Day, Year)
	08		* Kolt d.	(icho		H005619	7	4-7-70	-
	18		30. Name and address of person who	completed cause of death (II	em 23a) (Type, F				<u> </u>
	10		Robert A. C	wk-10 214	8 Ne	whom ST S.	Alisbury.	MS 2180/	
	Sta Registra	te ar	31. Date filed (Month, Pay Year) 8 2	32. gistrar's Sig	nature	2.00.	(		

	ľ	For State Registrar	State of Marylan			of Health and of Death	Mental Hy	giene	13628
		1. Decedent's Name (First, Middle, La	nst)				2. Date of De	eath	3. Time of Death
Physici /Medio Examir	cal	Beletu Kassas 4a. Facility Name (If not institution, giv	<u></u>		4b. City, To	wn, or Location of De		Day Yea 3, 2005 4c. County of De	3:59 pm
Lauiiii	101	Washington Adv		ita1	101 20	na Park		Montgom	
Funeral Director		5. Social Security Number 6. S	6ex 7. Age ( <i>In yrs</i> . 1□ M 2\ 7 5 4		If Under 1		n. (Month, Da	rth ay, Year) 9. B	erry irthplace (State or Foreig Country) Ethiopia
D .		Usual Residence of Decedent	10-0	-					
death with the Maryland ms 23e or 28e-f show traust be notified at	ctor	MD 10a. State 10b. County Montgo		y, Town or Lo					10d. Inside City Limits  X□ Yes 2 □ No
or 2	Dire	10e. Street and Number			10f. Zip C	ode		10g. Citizen of What (	Country?
ath v	<u>a</u>	18001 Rocking				874		USA	
<u> </u>	by Funeral Director	11. Marital Status  1 Never Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces?  1 ☐ Yes 2 No If Yes, Give Year or Dates:		Was Deceder If Yes, specify 1 ☐ Yes 2[	nt of Hispanic Origin? Cuban, Mexican, Pu	(Specify Yes or No erto Rican, etc.)	14. Race - An Black, Wh Specify: B1	
d within 72 hours aff giene. ar than "natural", or the Medical Exam	Completed	15. Decedent's E (Specify only highest gr. Elementary/Secondary (0-12)	ducation	16a. Dece (Give life.	dent's Usual ( kind of work DO NOT use	Occupation done during most of w retired)	vorking	16b. Kind of Busines	
d with giene	E O	1 2	College (1-401 5+)	Cash	ier			Private	<b>:</b>
e file al Hy othe vant,	ВеС	17. Father's Name (First, Middle, Last	)	· · · · · · · · · · · · · · · · ·		18. Mother's N	ame (First, Middle	, Maiden Surname)	
uld b Ments rrked rric e	10	Kassaye Tiku				Senb	etu G/S	elassie	
nd 2 should be fill th and Mental Hy 27 la marked oth traumatic evan		19a. Informant's Name/Relationship (	**	19b. Mailir	ng Address (S			er, City or Town, State,	Zip Code)
and 2 ealth n 27		Henok Aynalem/	Son	1800	1 Roc	kingham 1	Place, (	Germantow	n,MD 2087
permit. Pages 1 a Department of Hee mportant: If itam any injury or otha		20a. Method of Disposition		lace of Dispo	sition (Name	of	Date	20c. Location - City of	r Town, State
Pag nent unt: I		1 MgBurial 2 □ Cremation 3 □ 14 □ Donation 5 □ Other (Special	g) Gat	eway	to He	aven   Ap	r. 7,20		Spring,
permit. Departr Importa any inji		21. Signatur of Funeral Service Lice	Kisn Salle	J 16	Name and A	Address of Facility  Ltimore I  th St NW	Funeral	Home	
cate be executed /Medical Examiner bhysician and the burial-transit the burial-transit	Examiner	23a. Part1. Enter the disease, o common shock, or heart failure. List only limediate Cause (Final disease or condition resulting in death)  Sequentially list condition if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of the consequence of t	unce of):  4 uence of):	truy	Deseas	-	ilest,	Approximate Interval Between Onset and Death
The law requires that the death certificate be executed atte has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	d	death 3	Ectopic preg Other (speci			23d. Date of de Month	blivery Day Year
uires that signed b	þ	Part II. Other significant conditions of	ontributing to death but not resu	ulting in the u	nderlying caus	se given in Part I.	23e. Did t	obacco use contribute t	to the cause of death?
sician: The law requires t certilicate has been signe rector, page 2 should be c	Completed						24a. Was autop perio 1 □ Yes	osy prior to death?	
sician: T certificate irector, pa		25. Was case referred to medical examiner?				26. Place of D	eath Check onl		
	2	1 ☐ Yes 2∑ No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatien	t 3 <del>Q</del> DOA	Other: 4 Nursing	Home 5 Resid	dence 6 Other (Spi	ecify)
ling I. Afte une	Certification;	27. Manner of Death  XXI Natural 5 Pending investigation		28b. Time of Injury	28c.	Injury at Work? 1 Pes 2 No	28d. Describe I	how injury occurred	
ital or Attancirs after deathral Director:	Certific	3 Suicide 6 Could not b 4 Homicide determined	building, etc. (Specify	")			City or Tov		
To the Hospitel of within 24 hours at To the Funeral D completely filled it	edical	29a. Certifier 1 Certifying Place (Check only one) 2 Medical Example 1	ysician: To the best of my kno- niner: On the basis of examinal and mariner stated.	wledge, death tion and/or inv	occurred at trestigation, in	he time, date and plac my opinion, death occ	ce, and due to the curred at the time,	cause(s) and manner a date and place, and du	s stated. e to the cause(s)
To the Comp		29b. Signature and title of certifier				icense number		29d. Date signed (Mon	
		14/4	Like		4	5203		4-05	- 2005
(2)		30. Name and address of pers in who	completed cause of death (Item	23a) (Type,	Print)	RPAII ALL	E TAK	- ama Pap	- 2005 k, Md, 2091
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			For State Registrar	State of Maryla		rtment of He		ental Hygie	2000	13629
	Physici /Medic Examin	al	1. Decedent's Name (First, Middle) Last,  ROY  4a Fecility Name (If not institution, give)  ROY  4a Fecility Name (If not institution, give)	street and number)	<u>.</u> .e		ry, M	2. Date of Death		3. Time of Death  //SS M
	Funeral Director		5. Social Security Number 6. Se  221-40-4234  Usual Residence of Decedent	X 7. Age (In yr.	s. last birthday) / Yrs.		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y May /2,	(ear) 9. Birthp Cour 1953 Lewe	lace (State or Foreign http:/ s, Delaware
	ne Maryland 8a-f ehow	Director	10a. State 10b. County  Maryland Worceste		City. Town or Lo Delmar					0d. Inside City Limits 1 1 Yes 2 No
	with the or 2		10e. Street and Number 9414 Stable Roa	a d		10f. Zip Code 21875			. Citizen of What Cour Jnited Stat	•
36	4 within 72 hours after death with the Maryland Jiene. r than "natural", or Heme 23a or 28a-f ehow The Medical Examirat must be motified at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 ☑ Divorced	12. Was Decedent Ever in Armed Forces?  1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	11	Vas Decedent of Hisp Yes, specify Cuban,	panic Origin? (Spe Mexican, Puerto Specify:	ecify Yes or No-	14. Race - Americ Black, White, Specify: Wh:	ean Indian, etc.
21215-0036	within 72 ene. than "na	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation le completed) College (1-4or 5+)	(Give	ent's Usual Occupation of work done dure to NOT use retired) k Driver	on ring most of worki	ing 16	b. Kind of Business/In	dustry
nd 2	othe ent,	Be Co	17. Father's Name (First, Middle, Last)			1	8. Mother's Name	(First, Middle, Ma	iden Sumame)	
Maryland	should be nd Menta rmarked umatic ev	Tof	Robert H. Long	and Defeat	10h Mailin	a Address (Ctrast as		r F. Hito	chens City or Town, State, Zip	Codel
			19a. Informant's Name/Relationship (T)  Robert H. Long	(father)		oore's Cro			o, DE 1996	
altimore,			20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State Da	Place of Dispo- cemetery, cren agsboro cmetery	sition (Name of patory or other place) Redmen's			c. Location - City or To Dagsboro,	
Balt	permit. Pege Department of Important: If eny Injury or		21. Signature of Funeral Service Licens  Reckers T: (	Vatson	W	Name and Address atson Func illsboro,	eral Home Delaware	e		
	Pnysician /Medical Examiner	er	23a. Part1. Enter the disease, or comp. shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions.	ilications that caused the dene cause on each line.  a. Due to (or as a const.)  Due to (or as a const.)	equence of):	er the mode of dying,	such as cardiac c	no respiratory arrest	Pring	Approximate Interval Between Onset and Death
8760,	death certificate be executed ettending physicien end of for use as the burial-transit	dical Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a conse	equence of):					
.O. Box 6	thet the death certific led by the ettending p detached for use as I	Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No	23c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown	etal death 3	Ectopic pregnancy Other (specify)			23d. Date of delive Month	ery Day Year
rds, P	sign d be	ρχ	Part II. Other significent conditions co	ntributing to death but not re	esulting in the ur	nderlying cause given	in Part I.	23e. Did toba	cco use contribute to the	
al Records,	The ete h page	Completed						24a. Was an autopsy performe	24b. Were autoprior to codeath?	psy findings available mpletion of cause of
Vital	9 8	o Be	25. Was case referred to medical examiner?	Hospital: 1 Impatient 2	☐ ER/Outpatien			n <i>(Check only one)</i> me 5□ Residen	ce 6 □Other (Specil	(v)
ion of	ing After une		27. Manner of Poath   Shatural 5   Pending   P	28a. Date of Injury (Month, Day Year)		28c. Injury a Work?		28d. Describe how		,,
Division	200>	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spe	t home, farm, str cify)	eet, factory, office		28f. Location (Stre City or Town,	et and Number or Rura State)	al Route Number,
	To the Hospital or within 24 hours efter To the Funeral Directorplately filled in b	edical	(Check only 2 Medical Exami	rsician: To the best of my k iner: On the basis of exami and manner stated.		restigation, in my opir	nion, death occurr	ed at the time, date	e and place, and due to	the cause(s)
)	Mil To Too	2	29b. Signature and title of cartifier	004	na	29c. License n	6278	290	1. Date signed (Month,	05 Nalfa
3	Sta Regista		30. Name and address of person who could be seen and address of person address of person and address of person address	32. Registrar's Sig	1 H51	Print) W C	Bx 17	33 Sa	65 1	walfa

DHMH 17 Rev 1/2001

ORIGINAL

PHE	N R. L	IGH	TTNER 1- State Registrar		ryland / Depa <i>Cei</i>		lealth and Me	ental Hygie	•	13630
	Dhysis		1. Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day Year	3. Time of Death
	Physic /Medi		Stephen Ralph Lig	htner					5, 2005	.0437 A M
	Exami		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Death		4c. County of Death	
			119 ROBERTS WAY			NORTH			CECIL	
	Funeral Director		221-36-2131	7. Age	(In yrs. last birthday) 54 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Month, Day, Y July 13,	(ear) 9. Birthp Cour	lace (State or Foreign htry) NC
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	cation				Od. Inside City Limits
	Maryl 1 sho	ţō	MD Cecil		North E	ast				1 ☐ Yes 2 🕱 No
	7 28a	Funeral Director	10e. Street and Number		Novem E	10f. Zip Code		100	J. Citizen of What Cour	ntry?
	3a o	0	119 Roberts Way			21901			USA	
	deati	Jer		12. Was Decedent Ev	ver in U.S. 13.	Was Decedent of H	ispanic Origin? (Spec In, Mexican, Puerto P	ify Yes or No-	14. Race - Americ	
020	72 hours after death with the Marylan "natural", or Items 23a or 28a-f show cleal Examiner must be notified at	þ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 □ Yes 2 □ No If Yes, Give Year or Dates:	•	f Yes, specify Cuba I□ Yes 2【 No		lican, etc.)	Specify: Whi	
21215-0036	C	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation	16a. Deced	lent's Usual Occupa kind of work done of DO NOT use retired	ation during most of workin f)	g 16	Sb. Kind of Business/Inc	dustry
7	filed withir Hygiene. ther then	TO.		4 +	Tru	ck Driver	L		Transporta	tion
<u> </u>	should be filed nd Mental Hygis marked other matic event, II	Be (	17. Father's Name (First, Middle, Last)				18. Mother's Name	(First, Middle, Ma	iden Sumame)	
Maryland		0	Ralph Lightner				Eleanor	Ignatou	<i>iski</i>	
a	S S S		19a. Informant's Name/Relationship (Ty	pe, Print)	19b. Mailin	ig Address (Street a	and Number or Rural	Route Number, C	City or Town, State, Zip	Code)
	1 and 2 Health em 27 i		<u>Linda Lightner/wi</u>	se	119	Roberts U	Vay, North	East, N	ID 21901	
ore	0 0		20a. Method of Disposition 1 □ Burial 2 1 □ Cremation 3 □ R	emoval from State	20b. Place of Dispo cemetery, cren	sition (Name of natory or other plac	θ) 04-08	-2005 20	c. Location - City or To	wn, State
Ě	Pag ment ant: i		'4 □Donation 5 □ Other (Specify)	emovar nom State	R.T. Foar	d Funeral			sing Sun.	MD
ballimore,	permit. Pag Department Important: I eny injury o		21. Signature of Funeral Service License	Po Room	1 22	. Name and Addres	ss of Facility R.T.	Foard F	uneral Hom n. MD 219	e, P.A.
			23a. Part . Enter the disease, or complishock, or heart failure. List only or	cations that caused t	e death. Do not ente					Approximate Interval Between
	/Medical Examiner	i Examiner	Immediate Cause (Final disease condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a  Due to (or as a	consequence of):  consequence of):	A COMPLICA	ates by Hyper	TENSIVE MON	inscreasing CAR	Onset and Death
8/60,	cate be ex chysician the burial	icai				_				
O. BOX 6	I ne law requires that the death certificate be exacuted to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at ti 9 ☐ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of delive Month	ry Day Year
л Э	mar i ed by detai		Part II. Other significant conditions con	tributing to death but	not resulting in the ur	nderiving cause give	en in Part I.	23e. Did toba	cco use contribute to th	e cause of death?
g.	quires n sign uld be	ed by	CHRONIL PERITO					1 ☐ Yes	2 No 3 Prob	ably 4 Unknown
Vital Records,	ine faw requir ate has been sj page 2 should	Completed	DIABRTES M	ECCITUS				24a. Was an autopsy performe	d? prior to cor death?	psy findings available appletion of cause of
		Φ	25. Was case referred to medical				26. Place of Death		1140	2 140
<b>5</b> :	ysic s ce dire	O.B	examiner? 1™ Yes 2□ No	lospital:	t 2 ER/Outpatien	t 3 DOA Othe			ce 6 Nother (Specify	AT COUNT
	ath. rr: Afte	Certification: T	27. Manner of Death  1 Natural 2 Accident 3 Suicide 6 Could not be determined	28a. Date of Injury (M. nth, ay) 28e. Price of Injury building, etc.	Year) Injury A	28c. Injury Work	Yes 2 No L	Bd. Describe how SUNN STAIR ANDED ON	injury occurred SUA 2'S AMD WHE! TO LE IM et and Number or Rival State)	estect fell elemane
	urs al			1		TIME	/	VURTH E	157, 100	
:	o the Hospital of Atternation 24 hours after de To the Funeral Directo completely filled in by the	ledical	29a. Certifier  (Check only one)  1 Certifying Physics  2X Medicel Exemination	sicien: To the best of ner: On the basis of e and manner state	examination and/or inv	occurred at the time restigation, in my operation	ne, date and place, ar pinion, death occurred	nd due to the caus d at the time, date	se(s) and manner as st a and place, and due to	ated. the cause(s)
3	within 2 To tha	Me	29b. Signature and title of certifier	1 1/		29c. License	number	29d	. Date signed (Month, I	Day, Year)
	> = 0		<b>)</b> / // /	Mr		00	CME	A	PRIL 6, 2	005
1	TIM		30. Name and address of person who co	mpleted cause of dea	ath (Item 23a) (Type,		<del></del>			
,	. ,		Mary a.	MIP US	, nD	111 Pe	nn Street	Baltim	ore, Maryla	and 21201
	Sta Registi		31. Date filed (Month, Day, Year)	32. Registrar	's Signature					

			For State Registrar	State	of Marylar		artment of F		and M		giene Reg. No.	)05	13631
	Physici	an	Decedent's Name (First, Middle							2. Date of De. Month	Day	Year	3. Time of Death
	/Medic		LAWRENCE JAMI  4a. Facility Name (If not institution				4b. City, Town, o	r Location o	f Death	APRIL		2005 County of Dea	0:10F
	LAUITIII		7901 ANCHOR S	STREET			_H	YATTSV		Ξ	I	PRINCE	GEORGES
	Funeral Director		5. Social Security Number 578 74 1681	6. Sex XX M 2□ F	7. Age (In yrs.	last birthday) 50 Yrs.	If Under 1 Year Months Days	If Under a	Min.	8. Date of Birl (Month, Da SEP • 29	y, Year)		thplace (State or Foreign ountry) SHINGTON, DC
	yland yland		Usual Residence of Decedent  10a. State 10b. County		10c. C	ity, Town or Lo	cation						10d. Inside City Limits
	a-f sh	ctor	DC		W	ASHINGT	ON						XX Yes 2 No
	or 28	Funeral Director	10e. Street and Number				10f. Zip Code				10g. Citiz	en of What C	ountry?
	eath v	erai	2520 17TH ST. I		cedent Ever in U	19 13		20018	nin2 /Sne	cify Vas or No		LTED ST	
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 ia marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, If a M-dical Exercit at the notified at once.	by	1 Never Married 2 Mar 3 Widowed XX Divorced	ried 1 Tyes	Forces? XXINo Sive	j	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes XX No		, Puerto F	Rican, etc.)		Black, Whi	te, etc.
21215-0036	72 hou natura	Completed	15. Deceder (Specify only highe	it's Education	1)	16a. Dece	dent's Usual Occup kind of work done	ation during most	of workin	og .	16b. Kin	d of Business	/Industry
2	vithin ne.	mple	Elementary/Secondary (0-12)		(1-4or 5+)	life.	DO NOT use retired	d)			43655	) T (   1) T	NED CDOGG
	filed v Hygie other t	ပိ	12TH 17. Father's Name (First, Middle,	Last)		RECOR	MOBILE			(First, Middle,			RED CROSS
Maryland	uld be Aental rked c tic eve	To Be	JAMES EDWARD Mo	COY				MAMII	E GRI	EENE			
az	2 should and Men ta marke aumatic		19a. Informant's Name/Relations	ship (Type, Print)		19b. Mailir	ng Address (Street	and Numbe	r or Rura	Route Numbe	er, City or	Town, State,	Zip Code)
e, Z	1 and Health em 27 ther tr		CLARENCE McCOY  20a, Method of Disposition	- BROTHE			ANCHOR S	т.		TTSVIL		4D 2078 ation - City or	
nor	Pages nent of th int: If Ite		XIX Burial 2 Cremation		n State	cemetery, crei	natory or other plac					,	
Baltimore,	permit. P Departme Importan any injur;		* 4 ☐ Donation 5 ☐ Other (S		FOI		COLN CEME RAME and Addre CARSHALL S					ENTWOOL	
ñ	Der mp any		1 7. 11	Tarshe	l	M/ 43	RSHALL'S 308 SUITL	FUNEI AND RO	RAL I OAD	HOME OF SUITLA	MARY ND, N	YLAND, 1 4D 2074	INC. 46
	Pnysician /Medical		23a. Part1. The the disease, o shock, or heart failure. List immediate Cause (Final disease or condition resulting in death)	a	caused the deal each line.  END STACO (or as a consecutive consecutive)	GE - AI		ng, such as	cardiac o	respiratory ar	rest,		Approximate Interval Between Onset and Death
	Examiner		O				OF LUNG						
	P #5	iner	Sequentially list conditions, if any leading to make a cause. Enter Underlying		o (or as a consec								
	xecute and al-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due t	o (or as a conse	quence of);							
8760,	cate be executed oblysician and the burial-transit	calE		đ									
9	rtificate ng phys as the	ਰ	IF FEMALE:										
D. Box	The law requires that the death certific tie has been signed by the attending p bage 2 should be detached for use as i	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live	utcome of pregn birth 2 ☐ Feto gnant at time of o tnown	el death 3[	Ectopic pregnancy Other (specify)	1			23	3d. Date of de Month	livery Day Year
ls, P.O.	ires that the di signed by the I be detached	by	Part II. Other significant conditi	ons contributing to	death but not res	sulting in the u	nderlying cause giv	en in Part I.					o the cause of death?
000	v requir been si should	Completed	CACILLYIA							24a. Was			utopsy findings available
Re	he lav e has age 2	duic								autop	rmed?	prior to death?	completion of cause of
ta		Be C	25. Was case referred to medica examiner?	1				26. Place	of Death	1 ☐ Yes (Check only o		1 🗆 Yes	
Division of Vital Records,	Attending Physician: r death. actor: After this certifici by the funeral director, i	၉	1 ☐ Yes XX No			ER/Outpatier				ne 5 ☐ Resid			BROTHER'S  Pairly RESIDENCE
u O	ding F	tion:	27. Manner of Death  XX Natural 5 ☐ Pendir  2 ☐ Accident investi		e of Injury onth, Day Year)	28b. Time o Injury	Wor	yat k? Yes 2.⊟1		8d. Describe h	now injury	occurred	
/ISI	Attender death	ifica	3 ☐ Suicide 6 ☐ Could	not be 28e. Pla	ce of Injury - At h	ome, farm, str	eet, factory, office			8f. Location (5	Street and	Number or R	ural Route Number,
	tal or A	Certification:	4 Homicide	buil	ding, etc." (Speci	ity)			194	City or Tox	vn, State)		
	o the Hospital or Attending Ph ithin 24 hours after death. io the Funeral Diractor: Atter thi ompletely filled in by the funeral	edical	29a. Certifier (Check only one)  XIX Certifyii 2 Medical	ng <b>Physician:</b> To the Examiner: On the and ma	he best of my kn basis of examina inner stated.	owledge, deat ation and/or in	n occurred at the tir vestigation, in my o	me, date and pinion, deat	d place, a th occurre	nd due to the d d at the time,	cause(s) a date and p	ind manner a place, and due	s stated. e to the cause(s)
	To the within 2 To the omplet	M	29b, Signature and title of certifi			MD	29c. Licens	311	+14	-	29d. Date	signed (Mont	th, Day, Year)
K	-(1)		30. Name and address of person M. RUIZ, M.D	. (	1	10 IRV	Print)	NW #:	2A56	WASHI	NGTO	N, DC 2	20010
	Sta ** Registr		31. Date filed (Month, Day, Year,  APR 0 8	2005	Registrar's Sign	ature do	uli						
			AIN U O		/	-							

6-0 # S

ald

Physician /Medical Examiner

The law requires that the death certificate be executed Box 68760. P.O. Division of Vital Records, Hospital or Attending Physician:

Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** Dona<sub>1</sub>d Meredith 2005 April /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Peninsula Legional Medical NICOMICO 8. Date of Birth (Month, Day, Year) Feb. 29, 19 5. Social Security Number 6. Sex 1 AM 2 ☐ F 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours Min Yrs. Director 218-20-9564 1928 Maryland Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Directo Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? With 30542 Berwyn Circle USA 21804 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1.⊠Yes. 2□No 1945— Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 2 should be filed within 72 hours efter and Mental Hygiene. 1 □ Never Married 2 Married 1 ☐ Yes 2 ☐XNo Specify: If Yes, Give Year or Dates: Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Distributor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ဥ Norman Meredith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 Anna Meredith- wife 30542 Berwyn Circle Salisbury, MD 21804 Item 27 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages nent of } Department of Important: If It any injury or o once. ` 4 ☐ Donation 5 ☐ Other (Specify) Crematory of Delmarva 4/8/2005 Delmar, Delaware 22. Name and Address of Facility Bounds Funeral Home 21. Signature of Funeral Service Licenses 705 E Main Street Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that ca shock, or heart failure. List only one cause on ea Immediate Cause (Final Approximate Interval Between Onset and Death sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner as the burial-transit resulting in death) Last Due to (or as a consequence of Physician/Medical IF FEMALE: nse : 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 Live birth 2 Fetal death ō in the past 12 months? Month 4☐ Pregnant at time of death 5 Other (specify) 1 Yes 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate 1 Yes 2 000 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After Injury 1 Natural 2 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No investigation after death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ģ 4 | Homicide within 24 hours afte To the Funeral Dir 29a. Certifier 1 🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.O. 100 E CARROLL 51. gistrar's Signature Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

MALLARD BAY CARE CENTER  CAMBRIDGE  S. Social Security Number  543-07-3298  CAMBRIDGE  S. Social Security Number  10a. State  10b. County  10c. City, Town or Location  CAMBRIDGE  Social Security Number  10a. State  10b. County  10c. City, Town or Location  CAMBRIDGE  Social Security Number  10a. State  10b. County  10c. City, Town or Location  CAMBRIDGE  Social Security Number  10a. State  10b. County  10c. City, Town or Location  CAMBRIDGE  Social Security Number  10a. State  10b. County  10c. City, Town or Location  CAMBRIDGE  Social Security Number  10a. State  10b. County  10c. City, Town or Location  10b. City Code  10c. City Code  10c. City Code  10d. Zip Code  10g. Citizen  10d. Zip Code  11d. Marital Status  11d. Mari	unty of Death  RCHESTER  9. Birthplace (State or Foreign Country)  South Dakota  10d. Inside City Limits  1 🖾 Yes 2 🗆 No  of What Country?
Physician /Medical Examiner  Arthur Max Martin  4a. Facility Name (If not institution, give street and number)  MALLARD BAY CARE CENTER  CAMBRIDGE  Month April 6, 200  4c. Cou  CAMBRIDGE  DOI  Funeral Director  5. Social Security Number 543-07-3298  1.24M 2.2 F 84 Yrs.  Usual Residence of Decedent	o5 5:05 a <sup>M</sup> unty of Death  RCHESTER  9. Birthplace (State or Foreign Country)  South Dakota  10d. Inside City Limits 1 ☑ Yes 2 ☐ No  of What Country?  A
MALLARD BAY CARE CENTER  CAMBRIDGE  5. Social Security Number 543-07-3298  CAMBRIDGE  To Age (In yrs. last birthday) 15 Age (In yrs. last birthday) 16 Age (In yrs. last birthday) 17 Age (In yrs. last birthday) 18 Age (In yrs. last birthday) 19 Age (In yrs. last birthday) 10 Age (In yrs. last birthday) 11 Age (In yrs. last birthday) 12 Age (In yrs. last birthday) 13 Age (In yrs. last birthday) 14 Age (In yrs. last birthday) 15 Age (In yrs. last birthday) 16 Age (In yrs. last birthday) 17 Age (In yrs. last birthday) 18 Age (In yrs. last birthday) 19 Age	PRCHESTER  9. Birthplace (State or Foreign Country)  South Dakota  10d. Inside City Limits 1 New 2 No  of What Country?
Funeral Director  5. Social Security Number 543-07-3298  1. May 2. F 84 Yrs.  5. Social Security Number 543-07-3298  1. May 2. F 84 Yrs.  1. Months Days Hours Min. (Month, Day, Year) 8/29/1920	9. Birthplace (State or Foreign Country)  South Dakota  10d. Inside City Limits 1 X Yes 2 No  of What Country?
Director  543-07-3298  124M 2 F 84  Yrs. Months Days Hours Min. (Month, Day, Year) 8/29/1920  Usual Residence of Decedent	South Dakota  10d. Inside City Limits 1 ☑ Yes 2 ☐ No of What Country? A
g g	10d. Inside City Limits 1 ☑ Yes 2 ☐ No of What Country?
Maryland Dorchester Cambridge    106. Street and Number   106. Street a	1 ⊠Yes 2 □ No of What Country?
The first of the f	of What Country?
520 Glenburn Ave.  21613  USi  11. Marital Status  12. Was Decedent Ever in U.S.  Armed Forces?  1 Never Married 2 Married  1 Never Married 2 Married  3 Widowed 4 Microced  15. Decedent's Education  (Specify only highest grade completed)  16b. Kind of work done during most of working	A
11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Married 1 Xes Specify Cuban, Mexican, Puerto Rican, etc.)  1 Xes Specify Cuban, Mexican, Puerto Rican, etc.)  1 Xes Specify No Specify:  1 Yes 2 No Specify:  15. Decedent's Education (Specify only highest grade completed)  16b. Kind of Give kind of work done during most of working	Dago - American Indian
1 Never Married 2 Married 1 XYes 2 No If Yes, Give Navy Year or Dates:  1 Never Married 2 Married 3 Widowed 4 X Divorced 15 Specify: Speci	Black, White, etc.
15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of working	ecify: White
(Give kind of work done during most of working	of Business/Industry
Elementary/Secondary (0-12) College (1-4or 5+) Infe. DO NOT use retired)	·
Bookkeeper Weldi	ing Supply
Elementary/Secondary (0-12)  College (1-4or 5+)  Bookkeeper  17. Father's Name (First, Middle, Last)  Max Foisey  Elementary/Secondary (0-12)  Media  Lucille Mingo	name)
The state of the s	wm State Zin Code)
19a. Informant's Name/Relationship (Type, Print)  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or To  844 Glen Dr., Bethany Beach, DE 19	
Thomas R. Defibaugh/Friend 844 Glen Dr., Bethany Beach, DE 19 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)  20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	on - City or Town, State
20a. Method of Disposition  20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)  3 Salisbury Crematory  4/6/05 Salis  21. Sunature of cemetery  22. Name and Address of Facility  22. Name and Address of Facility  23. Name and Address of Facility  24. Sunature of cemetery  25. Sunature of cemetery  26. Sunature of cemetery  27. Name and Address of Facility  28. Name and Address of Facility  29. Name and Address of Facility	sbury ~ MD
m o ccal little rolle Professio	nal Association
23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,	Approximate Interval Between
shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition  ANANCE  De mentice	Onset and Death
/Medical resulting in death)  Due to (or as a consequence of):	
Examiner  Sequentially list conditions, b.	
if any, leading to immediate cause. First Indoorlying Cause (Disease or injury)	
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a suffice a state a st	
The second of t	Date of delivery  Month Day Year
Spoop of the part	,
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	contribute to the cause of death?
S S S S S S S S S S S S S S S S S S S	o 3 Probably 4 Wiknown
24a. Was an autopsy performed?  1 Yes 2 No  24a autopsy performed?  1 Yes 3 No	4b. Were autopsy findings available prior to completion of cause of
autopsy performed?  1 □ Yes 3□ No	death?
The state of Death (Check only one)  25. Was case referred to medical examiner?  Hospital:	
25. Was case referred to medical examiner?  1   Yes 2   Subso   Hospital: 1   Inpatient 2   ER/Outpatient 3   DOA   Other: 4   Nursing Home 5   Residence 6   Other: 4   Nursing Home 5   Other: 4	
The state of the significant estimation of the state of t	curred
Natural 5 Pending investigation 5 Pending investigatio	umber or Rural Route Number,
28d. Date of Injury of Injury 28d. Date of Injury 28d. Date of Injury 28d. Date of Injury 28d. Date of Injury 38d. Date of Inj	
286. Place of Injury - At home, farm, street, factory, office  287. Location (Street and NL City or Town, State)  288. Place of Injury - At home, farm, street, factory, office  287. Location (Street and NL City or Town, State)  288. Place of Injury - At home, farm, street, factory, office  288. Place of Injury - At home, farm, street, factory, office  287. Location (Street and NL City or Town, State)  288. Place of Injury - At home, farm, street, factory, office  288. Place of Injury - At home, farm, street, factory, office  287. Location (Street and NL City or Town, State)  288. Place of Injury - At home, farm, street, factory, office  288. Place of Injury - At home, farm, street, factory, office  287. Location (Street and NL City or Town, State)  288. Place of Injury - At home, farm, street, factory, office  288. Place of Injury - At home, farm, street, factory, office  287. Location (Street and NL City or Town, State)  288. Place of Injury - At home, farm, street, factory, office  288. Place of Injury - At home, farm, street, factory, office  288. Place of Injury - At home, farm, street, factory, office  288. Location (Street and NL City or Town, State)  298. Certifier (Check only one)  299. Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and manner stated.  29b. Signature and title of certifier  29c. License number  29c. License number	I manner as stated. ce, and due to the cause(s)
29b. Signature and title of certifier 4 / 7 29c. License number 29d. Date signature	gned (Month, Day, Year)
F-3F-6	-05
1) 47929 4.6	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  NOMAN THANK 300 AURORA ST CAMERING 6 M  State Registrar  31. Date filed (Month, Day, Year)  APR 0 8 2005  APR 0 8 2005	0 2/6/3

		•	1 - For State Registrar	State of Marylan	•		nt of He <i>te of D</i>		nd Me		giene Reg. No.	2000	13634
	Physicia	an	1. Decedent's Name (First, Middle, Las						2	. Date of Dea Month	Day		3. Time of Death
	/Medic		Barbara Je							April		2005	7:45p M
1	Examin	er	4a. Facility Name (If not institution, give				, Town, or L					County of Dee	∍th
	Funeval		6801 Bock Road  5. Social Security Number 6. Se		last birthday)			lf Under 2	24 Hrs. 8	. Date of Birt	th	P.G.	rthplace (State or Foreign
	Funeral Director			DM 2ME	8 Yrs.	Months	Days	Hours	Min.	(Month, Da	y, Year)	1937	Wash.,DC
	p ,		Usual Residence of Decedent	100 00	y. Town or Lo								
	anyla ahov	'n	10a. State 10b. County										10d. Inside City Limits 1 X Yes 2 ☐ No
	the N	ecto	Md. P.G.	F,C	ort Wa		ngtor ip Code	1			10a Citi	izen of What C	
	death with the Maryland ms 23s or 28s-f show rmust be notified at	ă	6801 Bock Road	#345			20744	Į			-	ited S	
		Funeral Director	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	S. 13.	Was Dec	edent of His	panic Orig	in? (Speci	fy Yes or No- can, etc.)	-	14. Race - Am	
õ	after or Ite	Fu	1 XNever Married 2 ☐ Married	1 ☐Yes 2 No			ecily Cuban, 2≹ No		, rueito nii	can, etc.)		Black, Wh	
2-003p	hours after tural', or ite	d by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:			(4)	111		1		BI	ack
Ç	within 72 and the matter than "nat	Completed	15. Decedent's Ed (Specify only highest gra	de completed)	16a. Dece (Give	dent's Us kind of w DO NOT	ual Occupat ork done du use retired)	ion iring most	of working	,	16b. Ki	ind of Business	s/Industry
7 7	ifiled within Hygiene. other than rent, the M	mo	Elementary/Secondary (0-12)	College (1-4or 5+)			r Ana				Labo	or Dep	ot.
פ	Hyge to	BeC	17. Father's Name (First, Middle, Last)							First, Middle,			
yland		ToE	Henry D. Maho	ney				Beat	trice	e Dix	on		
Mar	~ ~ ~ =		19a. Informant's Name/Relationship (7		19b. Mailir 1505	ng Addre	ss (Street an rt Da	d Number	or Rural F	Route Numbe SE	er, City o	r Town, State,	Zip Code)
e,	D = C =		Charles Mahoney	· ·	Wash	ing	ton,	DC	St 2002		200 1 0	antian City a	Town State
ב ב	ages or of		1 Burial 2 ☐ Cremation 3 ☐		lace of Dispo							cation - City o	
IIII	it. Pa intmer intent njury	1	* 4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Licen		surre							inton, dwards	
g	permit. Pages 1 an Department of Heal Important: If Item 2 any injury or othar once.		anica) &	duanda	1 100					_			Md.20746
r	50		23a. Part . Enter the disease, or comp shock, or heart failure. List only	plications that caused the deatl								erana,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	a Myoccardia	Inf	arct	ion						Onset and Death
7 -	/Medical		resulting in death)	Due to (or as a conseq		агсс	.1011						nours
	Examiner		Sequentially list conditions.	b. Hypertensic									years
	Sit ad	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Unitedlying Cause (Disease or injury	Due to (or as a conseq									
_	be executed Ician and burial-transit	хап	that initiated events resulting in death) Last	c. Diabetes I		tus							years
2/60	ate be executed thysician and the burial-transit	ical E		4	, , , , , , , , , , , , , , , , , , , ,								
200	death certificate e attending phys d for use as the	ed		. u.									
X Q Q	eath certific attending p I for use as I	Physiclan/M	230. Was decedent pregnant	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta		TÉcto <b>n</b> ic	pregnancy					23d. Date of de	. ,
_	s deat he att ed for	sicla	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at time of d		Other (						Month	Day Year
J.	nat the de d by the a etached	Phy	9 Unknown		ulain a in also			in Book I		aza Dida			to the cause of death?
JS,	requires that een signed b nould be deta	by	Part II. Other significant conditions of	ontributing to death but not resi	uiting in the u	naeriying	cause given	in Part I.			res 2	. /	robably 4 DUnknown
cords,		Completed			_				_			_	
ě	The law ate has b bage 2 st	mpl								24a. Was autop perfo		prior to death?	utopsy findings available completion of cause of
Vital		e Co	25. Was case referred to medical					OC Disease	of Dooth (	1 Yes		1 □ Ye	s 200 No
	Physician: this certific ral director,	To B	examiner?	Hospital: 1   Inpatient 2	ER/Outpatier	nt 3 🗆 🗈	Othor			Check only o		6 □Other (Sp	acify)
0			27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o		28c. Injury a Work?			d. Describe I			,
DIVISION	Attending ir death. ector: Afte by the fune	atio	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation			М		es 2 🗆 N	10				
Ĭ	il or Attend after death Director:	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, str y)	reet, facto	ry, office		28	f. Location (5 City or Tox	Street an vn, State	d Number or F )	Rural Route Number,
2	pita vurs eral		One Continue A Continue of	valoion. To the beauty	ulad== 1 :	h -	4 = 4.01 - 12		4 -1-	4.4			
	Hospital 24 hours a Funeral stely filled	edical	29a. Certifier 1 Certifying Ph (Check only 2 Medical Examone)	ysician: To the best of my kno niner: On the basis of examina and manner stated.	wiedge, deat tion and/or in	n occurre vestigatio	d at the time in, in my opii	nion, deat	d place, and h occurred	d due to the at the time,	cause(s) date and	and manner a place, and du	e to the cause(s)
	To the Hos within 24 ho To the Funicom letely f	Med	29b. Signature and title of certifier	1 0 1		2	9c. License	number			29d. Dat	te signed (Mon	th, Day, Year)
1	FSFÖ		Alla A	Made Am	J. M.	T	3280	0		7	Apri	17,	2005
1	2(3)	Ų	30. Name and addr ss of person who	completed cause of eath ten	23a) (Type,			-			<u>.</u> . – -	,	
1			Halary H. Wash	ington 117	1 L1	vinc	ston	Ros	d, s	te 20	)5 F	't Wa	shington
8	Sta Registr	(6)	APR 0 8 2005	. Registrar's Signa		Al a							

			State of Maryland / Depart State Unpend Item 23a,27,28a-f per me G		•	•	10000
			Decedent's Name (First, Middle, Last)	modio of Bodin	2. Date of Death		3. Time of Death
	Physici		James Robert Marshall, III		APRIL	14, 2005	9:39p M
	/Medic Examin			4b. City, Town, or Location of Death SILVER SPRING		4c. County of Death MONTGOMERY	
777	Funeral Director		577-06-9846 18∑M 2□F 38 Yrs.	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, ) May 2,19	Year) 9. Birthp. Coun 966 Washi	lace (State or Foreign try) ngton, DC
6)	fand ow		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or Local	ation		11	Od. Inside City Limits
	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-1 show other traumatic event, the Medical Examiner must be notified at	Director	Maryland Montgomery Silver  10e. Street and Number	Spring	100	g. Citizen of What Coun	1 ☐ Yes 2 🛣 No
	3a or			20902			,.
	death ms 2	Funerai	1825 Billman Lane  11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. W. Armed Forces?	as Decedent of Hispanic Origin? (Spe	cify Yes or No-	USA 14. Race - America	
ဖွ	after or ite	T	1 X Never Married 2 ☐ Married 1 ☐ Yes 2 X No	Yes, specify Cuban, Mexican, Puèrto I □ Yes  2X No <i>Specify:</i>	Rican, etc.)	Black, White, e	atc.
933	Jraf,	d by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:			Specify: Bla	7.7.
21215-0036	natu	Completed	15. Decedent's Education 16a. Decede (Give ki	nt's Usual Occupation ind of work done during most of workir O NOT use retired)	ng 16	6b. Kind of Business/Ind	ustry
12	withir ene. then	шć	Elementary/Secondary (0-12) College (1-4or 5+)	ty Guard		School	
9	be filed within 72 hours after ital Hygiene. d other than "natural", or Ite event, the Medical Examine	Be Co	17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, Ma		
'lan	lid be fental rked tic ev	To B	James Robert Marshall, II	Sandra	B. Thoma	19	
Maryland	12 should be filed within h and Mental Hygiene. 7 Is marked other then " traumatic event, the Med			Address (Street and Number or Rura			Code)
	and 2 ealth n 27		Sandra B. Marshall Mother 1825 B	illman Lane Sil		ing Marylan	
Baltimore,	Pages 1 nent of H int: If iten		20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State  20b. Place of Disposition cemetery, crema Metropolit	tion (Name of trong or other place)	ate 20	Oc. Location - City or To	wn, State
Ë	tant:		`4 □Donation 5 □Other (Specify)	rematory Apr. 2	20,2005A1	exandria,V	irginia
Bal	permit. Pages 1 and 3 Department of Health Important: If item 27 any injury or other tr.		21. Signature of Funeral Service Licensee	Name and Address of Facility Incis J. Collins F	uneral H	Home, Inc.	
			23a. Part1. Enter the dispesse, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.	University Blvd.	,W.,Silv	ver Spring.	MD 20901 Approximate
	2		Immediate Cause /Final			.,	Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death)  Narcotic(heroin)into	oxication			
	Examiner						
	D #	ner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury				
	be executed ician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):				
760,	leath certificate be executed attending physician and I for use as the burial-transit	cai E	Due to (or as a consequence or).				
687	ficate physics the		d.				
Вох (	nding use a	□/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of deliver	ry
P.O. B	The law requires that the death certifica ate has been signed by the attending ph bage 2 should be detached for use as it	Physician/Med	in the past 12 months?	ctopic pregnancy Other (specify)		Month	Day Year
	that the ed by detac	/ Ph	Part II. Other significant conditions contributing to death but not resulting in the und	erlying cause given in Part I.	23e. Did toba	cco use contribute to th	e cause of death?
of Vital Records,	quires n sign ald be	d by			1 ☐ Yes	2 □ No 3 □ Proba	ably 4 Unknown
Ö	law requir as been s 2 should	Completed			24a. Was an	24b. Were autor	osy findings available
Re	ilcian: The lav certificate has rector, page 2	шо			autopsy performe Yes 2	ed? death?	npletion of cause of 2 \( \subseteq \text{No} \)
ital	sian: artifica ctor, p	Be C	25. Was case referred to medical examiner?	26. Place of Death			
Ž	Physic this ce al dire	To	1 ★ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient		ne 5 🗆 Residen		201111
no	Jing P	ion:	1 □Natural 5 □ Pending Found • Injury	Work?	8d. Describe how	injury occurred	unk
Division	I or Attendii after death. Director: A i in by the fu	icat	3 Suicide 6 Y Could not be		8f. Location (Stre	et and Number of Rural	Route Number
Di	after Direct	Certification:	4 Homicide  Adetermined  4 Homicide  Home		City or Town, ilver Sp	et and Number of Rural State) 1825 B11 ring MD	Iman Lane
	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medical C	29a. Certifier  (Check only (Physician) (Check only (P	occurred at the time, date and place, a	nd due to the cau	se(s) and manner as sta	ited. the cause(s)
	ithin it	Med	29b. Signature and title of certifier	29c. License number	290	d. Date signed (Month, L	Day, Year)
	- s + ō		/ V (when)	OCME	A	PRIL 15, 2	2005
			30. Name and address of person who completed cause of death (Item 23a) (Type, Pr	rint)	:		1 04 004
			J LARON LOCKEM	111 Penn Stree	t Balti	more, Mary	and 21201
	Sta Registr		31. Date liled (Month, Day, Year) APR 18 2005 32 egistrar's Signature	de la companya de la			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For amend item #1 per phy 8842 26/15 THE Registrar Per Funeral Home, 04/08/05, Certificate of Death WCHD, CH Reg. No. 1-Reg. No. Amended Item #7 2. Date of Death 1. Decedent's Name (First, Middle, Last) JOHN DAVID MESSNER, JR. April **Physician** Year 05 ≯ M Jonathon David Messner Jr. /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Worcester 429 Bayshore Drive, Unit 304 Ocean City If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
August 28,58 Pennsylvania 5. Social Security Number 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min 47 162-48-3920 Director 46 Usual Residence of Decedent the Maryland 10c. City. Town or Location r 28a-f show 10d. Inside City Limits 10a State 10b. County 1 Yes 2 No Director Ocean City MD Worcester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ other traumatic event, the Medical Eranings must be 429 Bayshore Drive, Unit 304 21842 USA Items 23a 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Mes 2 ☐ No If Yes, Give Year or Dates: 1977-1978 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. e filed within 72 hours after of Hygiene.

I Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: þ 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 4 Internet Companies Owner/Operator 12 17. Father's Name (First, Middle, Last) 18 Mother's Name (First Middle Maiden Sumame) 2 should be fill and Mental H Ella Brooks Jonathan David Messner 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 sment of Health an 429 Bayshore Dr. Unit 304, Ocean City, MD Cherie Robin Messner 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 Tremation 3 Removal from State Cape Henlopen Crem. 04/08/2005 Frankford, DE permit. Page Department of Important: If any injury or once. \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Burbage Funeral Home, 108

2/a. Part1. Entertible disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Burbage Funeral Home, 108 William St. Berlin, MD Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician ASPHYLIATION 37 HAWGING FW MINITES /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Unsease or injury Due to (or as a consequence of) burial-transit Cause (Disease or inju-that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760. physician the use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year jo in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 4 Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 🔀 No Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 2 Residence 6 Other (Specify) 2 🗌 No b 2 1**₩** Yes 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: Attending JECE ASED HUNG HIMSELF 5 Pending investigation 1 Natural after death.

Director: Af d in by the fur 5 1 Yes 2 No 04-04-65 2 Accident 6 Could not be determined 3 Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 429 BAY241 O.E.E. D.Z. & 229 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) HOME GEAN CITY, NO. 21842 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

C.H. 6+1

State Registrar 31. Date filed (Month, Day, Year) APR 0 8 2005

DOPOTHY

Atun 1

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



R.D.

1 06241

04-05-65

21863

SNOW HALL, MD.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year 1000 James Allen Miller **Physician** April 4:35 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Asbury-Solomons Health Care Center Solomons Calvert 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth

Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 1**∑**M 2□F 85 202 07 5420 Director 1920 Pennsylvania Usual Residence of Decedent death with the Maryland 10b. County 10c. City. Town or Location 10d. Inside City Limits 10a State item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 ☐ ★o Solomons Director Maryland Calvert 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Apt. 1302 20688 United States 11740 Asbury Circle Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: white 42 - 803 XWidowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry illed within nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4or 5+) 12 aeronautical engineer aeronautics 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) 12 shoutd be fi h and Mental H 7 is marked otl Be Bessie Hodson Miller Allen George 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 sinent of Health an Tina L. Burke -daughter 22316 Rolling Hill Lane Laytonsville MD 20882 20b. Place of Disposition (Name of cemetery, crematory or other place) Appril 6 2005

Metropolitan Funeral Service 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of Important: If it. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ö Alexandria Virginia `4 □ Donation 5 □ Other (Specify) injury 22. Name and Address of Facility 21. Signature of Funeral Service Licensee any ir Rausch Funeral Home 4405 Broomes Ts. rD. Port Republic MD 20676 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Polymonary F. brais **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Unisease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit law requires that the death certificate be executed Due to (or as a consequence of) attending physician Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Mellitus 1 Yes 2 No 3 Probably 4 Unknown director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an certificate has autopsy performed? 1 Tyes 2 No Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 2 No this funeral 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manger of Death 28d. Describe how injury occurred Certification: After t or Attending 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No death, 2 Accident after death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a Puneral ( Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical completely (Check only one) within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

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Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

State Registrar 30. Name and address of person who completed cause DIC

31. Date filed (Month, Day Yea

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32. Registra

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s Signature

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		-	For State Registrar	State o	f Marylan			t of H	ealth a		ental Hy	giene	005	13638
	Physicia	an	1. Decedent's Name (First, Midd Roland	le, Last)	Mors						2. Date of Dea Month March	ath	2005	3. Time of Death 11:25 A M
	/Medic Examin		4a. Facility Name (If not institution Millenium He			Cente			Location o			4c. C	ounty of Dea ne Ar	th
	Funeral Director		5. Social Security Number 213-01-8095	6. Sex 1 <b>)</b> X M 2 ☐ F	7. Age (In yrs. 93	last birthday) Yrs.	If Under Months	1 Year Days	If Under	Min. M	8. Date of Birt a Month 2 Day	, <b>19</b> 1	2 9. Bird	thplace (State or Foreign cuntry) ryland
	Maryland -f show	Į to	Usual Residence of Decedent  10a. State 10b. County  Iaryland	Calvert	10c. Cit	y, Town or Lo	hesa	peal	ke B	each				10d. Inside City Limits 1 ☐ Yes 2 XNo
	h with the 23a or 28e st be noti	Funeral Director	10e. Street and Number 3306 Dalry	mple Roa	d		10f. Zip	Code 20	732				in of What Co	ountry?
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "netural", or items 23a or 28a-f show important: If item 27 is marked other than "netural", or items 23a or 28a-f show any injury or other treumatic event, the Modical Examiner must be notified at ance.		11. Marital Status 1 □ Never Married 2 □ Mar 3 ☒ Widowed 4 □ Divorced	ried 1 Tes	2∭XNo ve		Was Deced If Yes, spec				cify Yes or No- Rican, etc.)		Race - Ame Black, Whit pecify: B1	e, etc.
Maryland 21215-0036	id within 72 he giene. er then "netu	Completed by		nt's Education ast grade completed) College (	1-4or 5+)	16a. Deced (Give life. 1	dent's Usua kind of wor DO NOT us Dri	rk done d se retired,	luring mosi )	t of workin sist	ant		of Business	/Industry 11ing
/land	wild be file Mental Hy arked other	To Be	17. Father's Name (First, Middle, Joseph		Morsel	1			18. Mothe		(First, Middle,	_	<sub>umame)</sub> amber	S
, Mar	and 2 sho balth and I n 27 Is ma		19a. Informant's Name/Relation Audrey S. Jo			P. 0	. Во	x 9		Ches		е Ве	ach,M	D 20732
Baltimore,	permit. Pages 1 and 2 Department of Health s Important; If item 27 li any injury or other tre		20a. Method of Disposition  1  ☐ Burial 2 ☐ Cremation  4 ☐ Donation 5 ☐ Other (3)  21. Signature of Funeral Service	Specify)	_   0		natory or o 1 o n d s	UMC	Cem	.4/5		Che		ke Bch.,MD
Ba	Dermi Depa Impo any lo		Blacky a.  23a. Part1. Enter the disease, of	Sewell	aused the deat								Fred	me .,MD20678
	Physician /Medical		shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death)	t only one cause on	each line.	Arrl					- Cophaioly an			Interval Between Onset and Death 5 m) Nu IES
68760,	te be executed wysician and burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	t. A+h Due to	(or as a conseq	ence of):	Ca	rdi	OVa	scu l	avy c(i)	seas	<b>9</b>	
P.O. Box 6	the death certifica y the ettending ph ched for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 Live	tcome of pregna birth 2 Teta nant at time of d	I death 3	Ectopic pr					23	d. Date of de Month	livery Day Year
	The law requires that the te has been signed by the age 2 should be detache	ed by Pr	Part II. Other significant condit									obacco usi		o the cause of death?
of Vital Records,		Completed by	Chronic O	bstructi	ve A	irwa	y o	lise	ase	ar			24b. Were as prior to death?	utopsy findings available completion of cause of
of Vita	Physician: Th this certificate ral director, pag	To Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital: 1 🗆	Inpatient 2				9r: 4 🛂 Nu	irsing Hom	(Check only one 5 Resid	dence 6		ocify)
Division (	Jing After fune	Certification:	3 ☐ Suicide 6 ☐ Could	igation	of Injury hth, Day Year) of Injury - At hing, etc. (Specif	28b. Time o Injury ome, farm, str	М		Yes 2 🗆	No	8d. Describe It	Street and		ural Route Number,
	To the Hospitel or Attent within 24 hours after deatl To the Funerel Director: completely filled in by the	edicai Ce	29a. Certifier 1 Certifyi (Check only one)	ng Physician: To th	e best of my kno casis of examina oner stated.	owledge, death	h occurred vestigation	at the tim	ne, date an pinion, dea	id place, a ith occurre	nd due to the ed at the time,	cause(s) a date and p	nd manner as	s stated. e to the cause(s)
)	To the within 2 To the comple	Med	29b. Signature and title of certifi			na,	290	License	number	353		29d. Date	signed (Mont	th, Day, Year) 2005
r	1		30. Name and address of person 5851 - De	who completed cau	se of death (Iter	n 23a) (Туре. Ном	Print) G	SYF	D-	.c.	SUR	ANI	9 2075	-/
	Sta Registr		31. Date filed (Month, Day, Yea	0 4 2005	Registra s Signa	ature	Apr	de la						

To tha Hospital or Attanding Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, after death. within 24 hours a

with the Maryland

Baltimore, Maryland 21215-0036

or 28a-f show

"natural", or Items 23a

Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. If item 27 Is marked other than "natural", or Items 23. permit. Page Department o Important: If any injury or once. Physician /Medical **Examiner** nding physician and use as the burial-transit (s) Additional Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Shoeshiles 10. 1/6/05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHEVERLY, MD 20185 S.T. SHASHIKANT 31. Date filed (Month, Day Year) 2005 Registar's Signature State DHMH 17 Rev 1/2001 **ORIGINAL** 

Registrar

		•	State of Maryland / Deparement    1- State   State   State   Cert	rtment of Health and M Fificate of Death		ne 005	3540
			Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death
	Physicia /Medic		Doris Ruth Norman		APril	2,2005	1455 M
	Examin		4a. Facility Name (If not institution, give street and number)  Peninsula Regional Medical Combo	4b. City, Town, or Location of Death Sallsburg		4c. County of Death	io
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Y		* <u>'</u>
	Director		Usual Residence of Decedent		8/17/192	5 Mar	yland
	/land		10a. State 10b. County 10c. City, Town or Loc	ation			10d. Inside City Limits
	ith the Marylar or 28a-f show	ctor	Maryland Wicomico Salisb	ury			1 ☐ Yes 2 ☐ No
	or 28	Director	10e. Street and Number	10f. Zip Code	10g	. Citizen of What Cou	ntry?
	death with the Maryland ms 23a or 28a-f show Littust by rictiffed at		112 Johnson Drive	21804	anifu Van or No	USA 14. Race - Ameri	can Indian
	ter de item	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Never Married 2 ☑ Married  1 □ Yes 2 ☑ No	as Decedent of Hispanic Origin? (Sp Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White,	
2	urs af	by	3 ☐ Widowed 4 ☐ Divorced	☐ Yes 2 X No Specify:		Specify: W	nite
2-003p	be filed within 72 hours after death with the Maryla. Ital Hyglene. d other than "natural", or items 23s or 28s-f shov event, its Masical Evantival mant be motified at	Completed	(Specify only highest grade completed) (Give k	ent's Usual Occupation ind of work done during most of work		b. Kind of Business/In	dustry
7	within ene.	mpl	Elementary/Secondary (0-12) College (1-4or 5+)	O NOT use retired)		Demontion	
7	filed w Hygie other t		12 – Hous	sewife 18. Mother's Name	e (First, Middle, Ma	Domestic  iden Sumame)	
and		To Be	Harold James Long		ive Smull		
3	ges 1 and 2 should be t of Health and Mental if item 27 is marked o or other traumatic eve	Ė		Address (Street and Number or Run	al Route Number, C	City or Town, State, Zij	o Code)
, Mai	and 2 ealth a n 27 is		Richard C. Norman Sr/husband 112	Johnson Dr., Sali			
Baltimore,	es 1 al of Hea if item or othe			atory or other place)		c. Location - City or To alisbury,	
Ē	Pag Iment tant: jury c		'4 □Donation 5 □Other (Specify) WICOILICO	raioriar	705 50	arrsbury,	כעיי
g	permit. Pages 1 Department of He Important: If Iten any injury or oth	-	21 Signature of Funeral Service Licensee CFSP Ho	Name and Address of Facility Olloway Funeral H	ome Profe	ssional As	sociation
			23a, Part1, Enter the disease, or complications that bused the death. Do not ente	)1 Snow Hill Rd., r the mode of dying, such as cardiac	Salisbur or respiratory arrest	y, MD 2180	Approximate Interval Between
	Physician /Medical Examiner	er	shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	tolec Brens	t Corn	inoro	Onset and Death  6 month
8/60,	cate be executed obysician and the burial-transit	dical Examine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  C.  Due to (or as a consequence of):  d.				
.O. Box 6	at the death certific by the attending pl	Physician/Me		Ectopic pregnancy Other (specify)		23d. Date of deliv Month	ery Day Year
Vital Records, P.	requires the	Completed by P	Part II. Other significant conditions contributing to death but not resulting in the un	derlying cause given in Part !.	23e. Did toba		
Rec	has be as ge 2 s	mp			autopsy performe	prior to co	ompletion of cause of
B		e Co	25. Was case referred to medical	26 Place of Dea	1 ☐ Yes 22 h (Check only one)	No 1 ☐ Yes	2 No
<u>=</u>	ysicia is cert direct	0 B	examiner?  1 Yes Hospital: Inpatient 2 ER/Outpatient	Other		ce 6 □Other (Speci	ity)
0	ng Phys ter this neral dir	n: T	27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Injury	28c. Injury at Work?	28d. Describe how	injury occurred	
0	endir eath. or: Af	catic	2 Accident investigation	M 1 Yes 2 No	201 1 11 12		
Division of	or Att	Certification:	4 Homicide  4 Homicide  4 Homicide  4 State Home determined  28e. Place of Injury - At home, farm, streed building, etc. (Specify)	et, factory, office	City or Town,	et and Number or Rur State)	al Houte Number,
J	To the Hospital or Attanding Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director.	edical Ce	29a. Certifier  (Check only one)  29 Medical Examiner: On the basis of examination and/or inv and manner stated.				
	o the othe	Med	29b. Signature and title of certifier	29c. License number	290	I. Date signed (Month,	Day, Year)
	F 3 F 8		mon to	036576		4/6/05	_
	1/2		30. Name and address of person who completed cause of death (Item 23a) (Type, I	_			
	100		RONALD P. TERWITE MD 560		OR DATIS	, MD 3	1001
	Sta Regist	ate rar	31. Date filed (Month, Day, Year), 8 2005 32. Refistrar's Signature	barke			

		,	1- State of Maryland / Depa Registrar Cen	rtment of Health and N tificate of Death	Reg.	ne N2 005   3641
	Physici /Medic Examin	al	Decedent's Name (First, Middle, Last)     THEODORE JACOB NOFFSINGER JR.  4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	2. Date of Death Month APRIL	Day Year 3. Time of Death 2 2005 0500 M  4c. County of Death
	Funeral Director		26620 WILLOWS LANE  5. Social Security Number  5. 77 - 42 - 3387  Usual Residence of Decedent  5. Social Security Number  6. Sex 1	EASTON  If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Yo AUG 12 19	TALBOT  9. Birthplace (State or Foreign MARYLAND
	the Maryland 28a-1 show	ector	10a. State 10b. County 10c. City, Town or Loc	STON	100	10d. Inside City Limits 1 ☐ Yes 2 ☑ No Citizen of What Country?
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatil and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic evant. It a Madical Examination must be notified at once.	d by Funeral Director	26620 WILLOWS LANE  11. Marital Status  1 □ Never Married 2 X Married  1 □ X Yes 2 □ No  1 □ X Yes 2 □ No	21601  Vas Decedent of Hispanic Origin? (Specify Cuban, Mexican, Puerto  ☐ Yes 2 ▼No Specify:		USA  14. Race · American Indian, Black, White, etc.  Specify: WHITE
3 21215-0036	filed within 72 ho Hygiene. ther than "natu nt, If e Medical	Completed	(Specify only highest grade completed) (Give killife. Differentary/Secondary (0-12) College (1-4or 5+)	ent's Usual Occupation kind of work done during most of work O NOT use retired)  ENTIST  18. Mother's Nam	ing	b. Kind of Business/Industry  DENTISTRY  iden Sumane)
Maryland	should be fand Mental I is marked of sumatic eva	To Be	THEODORE J. NOFFSINGER		BOGUESS	
Baltimore, M	Pages 1 and 2 ment of Health ant: If itam 27 i ury or other tre		20a. Method of Disposition 1 ☐ Burial ②☐ Cremation 3 ☐ Removal from State  20b. Place of Disposicemetery, crem	20 WILLOWS LANE, I sition (Name of natory or other place)  KE CREMATION CTR	Date 20	21601 c. Location - City or Town, State STEVENSVILLE, MD
Balt	permit. Departiment import any inj		Nosas 31 Oct. Ca Ca Fi	OO S. HARRISON ST	EASTON, I	M FUNERAL HOME PA MD 21601 Approximate Interval Between
	cate be executed // Medical Examiner    the private transit is the private transit    the p	Ical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, it any beauty to the reduction of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	lar Cancer.		9 gnset and Death 18 Months
P.O. Box 68	death certifi e attending ad for use as	Physician/Med		Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
Ś	w requires that the been signed by th should be detache	þ	Part II. Other significant conditions contributing to death but not resulting in the un	derlying cause given in Part I.		2 No 3 Probably 4 Unknown
Vital Record	The law ate has t page 2 s	e Completed	25. Was case referred to medical	26, Place of Deat	24a. Was an autopsy performed 1 Yes 2 High (Check only one)	24b. Were autopsy findings available prior to completion of cause of death?  No 1 Yes 2 No
Division of Vi	earding Physeath. or: After this the funeral dia	erification; To B	examiner?  1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient  27. Manner of Death  1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined  28a. Date of Injury (Month, Day Year)  28b. Time of Injury  28b. Place of Injury - At home, farm, streen building, etc. (Specify)	28c. Injury at Work? M 1 \( \text{Yes} 2 \( \text{No} \)	28d. Describe how	et and Number or Rural Route Number,
Ö	t hours a unaral lely filled	calC	4 Homicide building, etc. (Specify)  29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death 2 Medical Examiner: On the basis of examination and/or inv and manner stated.		and due to the caus	se(s) and manner as stated.
	To tha P	Medi	29b. Signature and title of certifier  Matthe Fisher MD	29c. License number		Date signed (Month, Day, Year)
5	FIVE				Mayland	21601
	Sta Regist		APR 0 5 2005  APR 0 5 2005	&		

				1 = For State Registrar	State of M	arylar	•		f Health and of Death		iene	05	13642
				Decedent's Name (First, Middle,	Last)					2. Date of Deat	h		3. Time of Death
		Physici /Medic	al	George 4a. Facility Name (If not institution,	Calvert		rris	4b City Tow	m, or Location of Dea	Month APRIL	10	Year 2005  Try of Death	10:49p <sup>M</sup>
		Examin	er	St. Mary's	•	,		•				•	1
		Funeral				ge (In yrs.	last birthday)	If Under 1 Ye		8. Date of Birth		t . Mar 9. Birthr	y S place (State or Foreign ntry)
		Director		214-30-1374	1 ∰ M 2 🗆 F	73	Yrs.	Months Da	ays Hours Min	Jan. 27,			land
		p. ,		Usual Residence of Decedent		10.00							0d. Inside City Limits
		anyla show	-	10a. State 10b. County		100. CI	ty, Town or Loc						1 ☐ Yes 2 🖥 No
		er death with the Marylan items 23a or 28a-f show her must be motified at	Funeral Director	Maryland St	. Mary's				nardtown		Da Citizaa	of What Cou	
		with to	급					10f. Zip Cod					,
		eath	eral	43658 Redmo	nd Road  12. Was Decedent	Ever in U	S. 13 V	Vas Decedent	of Hispanic Origin? (5			d Stat	
	10	fter d	Fun	1 Never Married 2 Marrie	Armed Forces'	?	52-		of Hispanic Origin? ( Cuban, Mexican, Puer	rto Rican, etc.)	В	lack, White,	etc.
	38	urs a	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1	☐ Yes 2	No Specify:		Spe	cify:Whit	e
	altimore, Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other then "naturel", or Items 23s or 28s-f show other treumatic event, the Medical Examinar must be multified at	Completed	15. Decedent' (Specify only highest	s Education		16a. Deced	ent's Usual Oc	ccupation	orkina	16b. Kind of	Business/In	dustry
	21	ithin	nple	Elementary/Secondary (0-12)	College (1-4or	5+)			one during most of wo stired)	9			
	21	led w lygier her th		12	1			Electri		me (First, Middle, M		Gover	nment
	and	be find Hall Hall Hall Hall Hall Hall Hall Hal	Be	17. Father's Name (First, Middle, L								,	
	ž	hould d Mei marke matic	5	Thomas Jerr	/		19h Mailin	n Address (St	Rose F reet and Number or R	rances Tr			Code)
	Ma	d 2 sl th an 7 is r treur											
	ē,	Heal Heal tem 2	17	Clara R. Norri  20a. Method of Disposition	s / wile	20b. F	Place of Dispos	sition (Name o	nd Road, L			n - City or To	
	no	ages ant of it: ff i		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp		'	emetery, crem .nsfield	-		5 <b>-</b> 2005 C	harla:	tto Un	11 MD
e-c	喜	perrit. Pages 1 Department of H Importent: if ite any injury or otl		21. Signature of Suneral Sarvice	-	DLI			ddress of FacilityBr				
	ñ	permit. Depart Import any inj gnce.		Edward N. Brins	rield. Sr.	МОС							20650-0279
				23a. Part1. Enter the disease, or shock, or heart failure. List of		d the deat	h. Do not ente	or the mode of	dying, such as cardia	ac or aspiratory arre	st,		Approximate Interval Between
		Pnysician	0 1	Immediate Cause (Final disease or condition	Only one cause of each	n De i	noul	mona	MIRANA	011	1000		Onset and Death
		/Medical		resulting in death)	aDue to	a consec	quents of):	VINITA	A	701			$\frac{n}{1}$
		Examiner		Cognosticilly list conditions	h CV	22	2020	el 1	Mom	TOTAL			2h25
-		₽ #	ner	Sequentially list conditions, I any leading to the challe cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consec	luence of):	1-	0	Dar	1	Si ni	1108
Jan Jan		The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	2rl	mer	e Levie	recurso	ula) b	1 8	20 =	9/20,
W.	90	oe execian a		resulting in death) cast	Joue to or as	s a consec	luence of):						U
YA	8760,	physic physic the b	dical		d							-	
	9 ×	eath certific attending p	Physician/Me	IF FEMALE:	23c. If yes, outcome	a of pregn	ancv				224 (	Date of dollar	
NORRIS	Вох	atten for us	ian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth	2 Feta	ıl déath 3 □	Ectopic pregna Other (specify				Date of delive Month	Day Year
ORI	P.O.	the de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unknown		.o	Guidi (apoon)	·/-				
		w requires that the deben signed by the should be detached		Part II. Other significant conditio	ns contributing to death	but not res	sulting in the un	derlying cause	e given in Part I.	23e. Did tob	acco use co	ontribute to t	he cause of death?
CALVERT	Records,	quires n sign	d by							1 □ Ye	s 2 📆 No	3 ☐ Prot	oably 4 Unknown
ΓΛΙ	00	w rec	lete							24a. Was a	241	o. Were auto	psy findings available mpletion of cause of
CA	Re	The la	Completed							autops perform	ned?	death?	
띮	ta		0	25. Was case referred to medical					26. Place of De	eath (Check only on		1	225110
GEORGE	<b>f</b> V	ding Physicien: th. : After this certifica funeral director, p	To B	examiner? 1 ☐ Yes 2 <b>∰</b> No	Hospital: 1  Inpat	ent 2	ER/Outpatient	3 □ DOA	Other: 4 Nursing	Home 5 Reside	nce 6 🗆 C	Other (Specil	y)
GE	0 U	ng Pt fter th neral		27. Manner of Death 1	28a. Date of Inj (Month, Date	ury ay Year)	28b. Time of Injury	28c. I	Injury at Work?	28d. Describe ho	w injury occ	urred	
	20	uttendii death. ctor: A y the fu	cati	2 Accident investig	ation				1 ☐ Yes 2 ☐ No				
	Division of Vital	or Att	Certification:	4 Homicide determi		itc. (Special	ome, farm, stre fy)	eet, factory, off	fice	28f. Location (St. City or Town		mber or Rura	Il Route Number,
		pital urs a		Continue of Continue	Physician: To the box	of mulea	awladaa daath		:				
		To the Hospital or Attending Physicien: within 24 hours after death.  To the Funeral Director: After this certifical completely filled in by the funeral director, I	edical		g Physician: To the bes Examiner: On the basis and manner s	of examina							
		To the I within 2 To the I complet	Me	29b. Signature and little of certifier		1	111	29c. Lic	cense number	25	d. Date sig	ned (Month,	Day, Year)
		F ≤ F ō		1 Jamos	It has	175	-AAL	JE	1064	19	47	13-1	25
				30. Name and address of person v	who completed cause of	death (Iter	m 23a) (Type, i	Print)		v /	v (		
				J. Patrick Jar	//				Road, Hol	lywood. M	arylar	nd 206	36
		Sta		31. Date filed (Month, Day, Year)	√ 32. Regi	ar's Sign	ature	And .	,	J	<i>y</i>		
		Registr	rar	V APR	1 2005	tion of		Secretary Secretary	-				

		₩.	1 - State Registrar	te of Maryland	d / Depa		of He	ealth a		ental Hygi	•	5	13613
	q		Decedent's Name (First, Middle, Last)							2. Date of Death Month	_	Year	3. Time of Death
	Physici /Medio		KODEH E. OCHIAM Apri							April 1	2005		8:20 P M
	Examir	er	4a. Facility Name (If not institution, give street and number)				4b. City, Town, or Location of Death				4c. County of Death		
			Country Home Ltd  5. Social Security Number  6. Sex  7. Age (In yrs. last birthday)  If Under 1 Year  If Under 24 Hr						24 Hrs.	Anne Arundel  8. Date of Birth 9. Birthplace (State or Fore			
	Funeral Director		079 - 05 - 5652 12 M 2		Yrs.		Days	Hours	Min.	(Month, Day,		New	ace (State or Foreign try) York
	yland 10w		10a. State 10b. County		, Town or Lo	cation						10	Od. Inside City Limits
	e-fst	ctor	MD Prince Geor	ge's Fo	orestv	ille							1 ☐Yes 2X No
	or 28	Director	10e. Street and Number			10f. Zip (				10	g. Citizen of Wh		try?
	s 23a	rai	5908 Addison Avenue	a Doordoot Ever in 116			2074		i-2 (C	=if - V = = = N =	US		an Indian
36	72 hours after death with the Maryland Inaturel; or Items 23a or 28e-f show Itest Examination matike and this of at	by Funerai	1 Never Married 2 Married 1	s Decedent Ever in U.S ned Forces? ]Yes 2 [] No es, Give ar or Dates:	1	fYes, speci 1 ☐ Yes 2			in? (Spe , Puerto l	cify Yes or No- Rican, etc.)	14. Race Black, Specify:	White, e	etc.
Maryland 21215-0036	2 hou	ted	15. Decedent's Education	late at	16a. Deced	dent's Usual	Occupa	tion	n f m who i	1	6b. Kind of Busi	iness/Ind	lustry
21,5	⊆ _ ⊴	Completed by	(Specify only highest grade completed)  [Give kind of work done during most life. DO NOT use retired)  [Give kind of work done during most life. DO NOT use retired)										
12	e filed with I Hygiene. other ther		12		Bui	lding				(First Middle Ad	<del>-</del>		anagement
anc	be del	Be	17. Father's Name (First, Middle, Last)  Erastus Abram Nort	hom						(First, Middle, M		,	
1	s 1 and 2 should be f Health and Menta item 27 is marked other treumatic ev	ပ္	Erastus Abram Nort  19a. Informant's Name/Relationship (Type, Pri		19b. Mailin	na Address	(Street a	Bern		Ruth I	Baxter City or Town, S	tate. Zio	Code)
	od 2 Ith a 27 is		Don Northam (son)		1					iendshi			,
ë,	es 1 ar of Hea fitem r other		20a. Method of Disposition	20b. Pl	ace of Dispo				Apri		Oc. Location - C		wn, State
E	0 0		1 ☐ Burial 2 ☑ Cremation 3 ☐ Remova  * 4 ☐ Donation 5 ☐ Other (Specify)		e Cre			,	200		Clinto	on, N	VID
Baltimore,	pernit. Pa Departmen Importent: any njury once.		21. Signature Fu eral Service Licensee							Funeral			
			23a. Parks. Enter the disease, or complications shock, or heart failure. List only one caus	s that caused the death									Approximate Interval Between
	Pnysician :		Immediate Cause (Final disease or condition	Ventrica	lar	arr	476	mia	7.				Onset and Death
	'Medical Examiner		resulting in death)	oue to (or as a consequ	enga of):	1-	16	4-	7):	ase			227(20100
	LXammer	<u>.</u>	Sequentially list conditions,	VIEV LOSO Due to (or as a consequ	lero	re 1	100	01 1	ise	ase		- 1	70 95
	ted nsit	Examiner	cause. Enter Underlying Cause (Disease or injury	oue to (or as a consequ	ierice dij.								/
,	be executed sician and burial-transit	Exar	that initiated events	Due to (or as a consequ	ence of):							_	
760,		cai	d										
68			IF FFMALE.									-1/-	
Вох	death certificat e attending phy d for use as th	Physician/Med		es, outcome of pregnar ]Live birth 2 ☐ Fetal		Ectopic pre	gnancy				23d. Date Monti		ry Day Year
.O.	0 0 0	sici	1 Vac 2 No 4L	]Pregnant at time of de ]Unknown	eath 5⊡	Other (spe	cify)				Morto	, ,	Day real
<b>Q</b> _	that the		Part II. Other significant conditions contributing	ng to death but not resu	tting in the ur	nderlying car	use aivei	n in Part I.		23e. Did toba	cco use contrib	ute to the	e cause of death?
ds,	signe d be	d by	Percheval vascular disease										
Decords.  The Baccords.  The Baccord					Curro 24a M					as an 24b. Were autopsy findings available			
So and the state of the state o							prie de:	r to completion of cause of th?					
Vital		0	25. Was case referred to medical				-	26. Place	of Death	(Check only one	<u> </u>	Yes :	2 No
Į V	di is	To B	examiner? 1 Yes 2 No Hospita	l: 1 🗆 Inpatient 2 🗆 E	ER/Outpatien	t 3 DOA	Other	. 4 🗆 Nur	sing Hon	ne 5 Residen	ce 6 Nother	Speciel	sted Living
n of	ding Ph h. After th funeral		27. Manner of Death 28a	Date of Injury (Month, Day Year)	28b. Time of Injury	28	c. Injury Work	at ?	2	8d. Describe how	injury occurred		
sio	Attendia death. ctor: A y the fu	cati	2 Accident investigation			М		es 2 □ N					
Division	after death after death Director: /	Certification:	4 Homicide determined 288	. Place of Injury - At hor building, etc. (Specify)	me, farm, stre	eet, factory,	office		2	8f. Location (Stre City or Town,		or Hural	Route Number,
	To the Hospitel or Attending within 24 hours after death.  To the Funerel Director: After completely filled in by the fune	edical C	29a. Centrer (Check only one) 1 Centrying Physician: 2 Medical Examiner: Or one)	To the best of my known the basis of examination dispersions of manner stated.	viedge, death ion and/or inv	occurred a restigation, i	t the time in my opi	e, date and inion, deat	place, a	nd due to the cau od at the time, dat	se(s) and manr e and place, an	er as sta d due to	ated, the cause(s)
	To the within To the	Me	29b. Signature and title of certifier.	1		- 1	License			290	I. Date signed (	Month, D	Day, Year)
			Toper le Ch	one mi	5		1)-	3629	16		4/5/	05	
	8		30 Name and address of person who complete Robert W. Olivine Mi	d cause of death (Item	23a) (Type, I					ooklyn	Park H	10:	21225
v	Sta Registr	ite ar	30. Name and address of person who complete Robert W. Oliving MZ 31. Date filed (Month, Day, Year)  APR 0 6 2	32. Registra Signat	ure K	Los	Les .		<u>:</u>				

B.K.S	Please Type or Print in Black Indelible Ink. Ensure All (	Copies Are Legible.								
DAVONDALE M.	PETERS State of Maryland / Department of Health and Med	ntal Hygiene								
	1- State Registrar amended 4-11-05 item # 7/wclfd974466ate of Death	Reg. No. 4005   3641								
Physician	1. Decedent's Name (First, Middle, Last)  Da Vondale Maurice Peters  2.	Date of Death Month Day Year  A DD TT 7 2005  3. Time of Death 1923 P M								
/Medical Examiner	4a. Facility Name (If not institution, give street and number) PENINSULA REGIONAL MEDICAL CENTER 4b. City, Town, or Location of Death SALISBURY	APRIL 7, 2005 1923 1 W 4c. County of Death WICOMICO								
Funeral										
Director	5. Social Security Number  6. Sex 128 Yrs.  7. Age (In yrs. last birthday) 128 Yrs.  138 Yrs.  149 (In yrs. last birthday) 15									
Iryland 21215-0036  should be filed within 72 hours after death with the Maryland of Mental Hygiene marked other then "natural", or Items 23e or 28e-f show imatic event, the Medical Examinational be notified at To Re Completed by Funeral Director	10a. State 10b. County 10c. City, Town or Location  MD WICOMICO SALIS bury	10d. Inside City Limits  12 Yes 2 □ No								
with the Mar or 28a-f si be notified	10e. Street and Number 10f. Zip Code	10g. Citizen of What Country?								
sath wi		U3A								
of the death of the temp 23 contractions 23 contractions 23 contractions 23 contractions and the temperature of the temperature	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married  13. Was Decedent of Hispanic Origin? (Specific Fig. 1) (Specific Fig. 2) (Specific F	y Yes or No- an, etc.) 14. Race - American Indian, Black, White, etc.								
DO3( urel:, o	3 □ Widowed 4 □ Divorced Year or Dates:	Specify: Black								
in 72 t	15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry								
Maryland 21215-0036 nd 2 should be filled within 72 hours att th and Mental Hygiene. 27 Is marked other then "naturel", or r treumatic event, the Medical Exami TO Re Completed by E	Elementary/Secondary (0-12) College (1-4or 5+) Home make									
and ibe file ntal Hy ed oth	17. Father's Name (First, Middle, Last)	irst, Middle, Maiden Sumame)								
re, Maryla s 1 and 2 should I Health and Meni Item 27 is marke other treumatic	HOWARD HAMES Johnson, In Sylvania C 19a. Informant's Name/Relationship (Type, Print), 19b. Mailing Address (Street and Number or Rural A	Oute Number, City or Town, State, Zip Code)								
m 27 Is	Bestrice Lavern Peters wife 413 TRuitt St. SAlab	ury MO 21804								
0 0	20a. Method of Disposition  20b. Place of Disposition (Name of cametery, crematory or other place)  20c. Method of Disposition (Name of cametery, crematory or other place)	2001 200211011 011) 01 701111 01210								
Baltime Department important: I	1. Senature of Viral Service Licensee  4 Donation 5 Dother (Specify)  HANDY Cent Teny 14-16-  2. Name and Address of Facility Box	05 UPPER HILL, MD								
Balti permit. Departi Importe eny inju	Just 917 Isabella St.	SAlisbury MO 21801								
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or reshock, or heart failure. List only one cause on each line.	Approximate Interval Between Onset and Death								
Pnysician /Medical	Immediate Cause (Final disease or condition resulting in death)  a. Multiple guishot u	OULOS GISSEL AND DEALIN								
Examiner	Due to (or as a a to equence of):									
	Sequentially list conditions, if any, leading to minediate cause. Enter Underlying									
60, be executed ician and burial-transit	Cause (Disease or injury that initiated events c									
prig pe										
c 687	IF FEMALE:									
P.O. Box 6876 nat the death certificate be d by the attending physici letached for use as the bu Physician/Medical	23b. Was decedent pregnant in the past 12 months?  4 Pregnant at time of death 5 Other (specify)	23d. Date of delivery  Month Day Year								
P.O. that the de detached detached	1 Yes 2 No 9 Unknown 9 Unknown									
	Part II. Other significant conditions continuously to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?  1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown								
The law requires the has been single as should		24a. Was an autopsy findings available prior to completion of cause of								
The law ate has page 2 s		autopsy performed? death? 12 Yes 2 □ No 12 Yes 2 □ No								
of Vital Physicien: rthis certifica	25. Was case referred to medical 26. Place of Death (C									
Of Physical chiral chir		5 ☐ Residence 6 ☐ Other (Specify)  I. Describe how injury occurred								
ision ttending death. ctor: Afte y the func	1 □ Natural 5 □ Pending (Month, Day Year) Injury Work? 2 □ Accident investigation → 7 5 3′30 A M 1 □ Yes 2 No	Doward Shot								
Division of Vital Records, tet or Attending Physicien: The law requires the all Director: After this certificate has been signed in by the funeral director, page 2 should be constitingation. To Re Completed by	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f	Location (Street and Number or Rural Route Number, City or Town, State)								
Spitet lours a neral f		due to the cause(s) and manner as stated.								
Division of Vital Re To the Hospitet or Attending Physicien: The within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page		at the time, date and place, and due to the cause(s)								
To t To t	29b. Signature and title of centrier  29c. License number  O.C.M.E	29d. Date signed (Month, Day, Year) APRIL 8, 2005								
6 m	30. Name and address of person who completed deadse of death (Item 23a) (Type, Print)									
VII	S. R. HOGAN 111 PENN STREET, BALTIMORI	E, MARYLAND 21201								
State Registra										
negistrai	WLU I I COOL PENNE N. WALL									

			State Registrer	e of Maryland / Dep Ce	partment of Hertificate of L			ene . No.2 (1) (1) (5)	1361.5
			Decedent's Name (First, Middle, Last)				2. Date of Death Month	Day Year	3. Time of Death
	Physicia /Medic		Gary Ogden Pyles		1 0 T		April	12, 2005	9:40A M
	Examin	er	4a. Fecility Name (If not institution, give street an	nd number)		Location of Death		4c. County of Deatl	
	Funeral		38000 Mt. Wolfe Road  5. Social Security Number 6. Sex	7. Age (In yrs. last birthda)		tte Hall If Under 24 Hrs. Hours Min.	8. Date of Birth	St. Mary	nplace (State or Foreign untry)
	Director		577-46-1000	71 Yrs.	Months Days	Tiours IVIII.	Jan. 17,	1934   Mar	yland
	land ow	1	Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or	Location				10d. Inside City Limits
	Mary a-f sh	tor	Maryland St. Mary's	Charlot	te Hall				1 ☐ Yes 2 No
	ith the or 284 re not	Director	10e. Street and Number		10f. Zip Code		10g	. Citizen of What Co	untry?
	s 23a		38000 Mt. Wolfe Road	Description 10	20622 Was Decedent of H		- Was as No	U.S.A.	rican Indian
9	in 72 hours after death with the Maryland "naturet", or Items 23a or 28a-f show calcal Exaciling cast be notified at	Funeral	1 Never Married 2 Married 1	Decedent Ever in U.S. ed Forces? Yes 2 2 No s, Give	If Yes, specify Cuba	n, Mexican, Puerto  Specify:	Rican, etc.)	Black, White	
21215-0036	hours urat',	d by	3 Widowed 4 Divorced Year	r or Dates:	edent's Usual Occup		16	ib. Kind of Business/	
15-	- 9	Completed	15. Decedent's Education (Specify only highest grade comple	eted) (Giv	re kind of work done of DO NOT use retired	during most of worki	ng	ib. Kind of business/	ndustry
212	d within giene.	Com	Elementary/Secondary (0-12) Colle	ege (1-4or 5+) Ca	rpenter			Construc	tion
pu	be filed ntal Hygi of other event, I	Be	17. Father's Name (First, Middle, Last)			18. Mother's Name	<i>(First, Middl</i> e, Ma Gertrude	iden Sumame)	
Maryland	should be and Mental markad o	오	Rhody Orme Pyles  19a. Informant's Name/Relationship (Type, Prin	tl 10b Ma	iling Address (Street			Sity or Town State 7	in Code)
Ma			Shirley A. Pyles/wif		88000 Mt.				
ore,	ss 1 and 2 of Health a ltem 27 ls		20a. Method of Disposition	20b. Place of Dis	position (Name of ematory or other place		ate 20	c. Location - City or	
altimore,	Page ment c ent: If ury or		1  Burial 2  Cremation 3  Removal  4  Donation 5  Other (Specify)	Trinity	Memorial	Gardens	pril 18, 2005	Waldorf,	
Balt	permit. Pages 1 Depertment of H Importent: If Ite any Injury or ot once.		21. Signature of Funeral Service Licenses	1 1 1 1 1 1 1					neral Home, e Hall, MD
П			23a. Part1. Enter the disease, or complications shock, or heart failure. List only one cause	that caused the death. Do not e	nter the mode of dyin	/			Approximate 20622 Interval Between Onset and Death (1)
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Non-Smal	1 cell	Lung	CAN	CER	14 months
	Examiner			ue to (or as a consequence of):		0			
	D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	ue to (or as a consequence of):					
	ecuted and transi	Examiner	that initiated events	ue to (or as a consequence of):					
8760,	be executed sician and burial-transit			de to (or as a consequence or).					
687	ificate t g physia as the b	edic	d						
Вох	eath certific ettending pl	an/M	23b. was decedent pregnant	es, outcome of pregnancy Live birth 2  Fetal death 3	B⊟Ectopic pregnancy	/		23d. Date of deli	very Day Year
.O. E	The law requires that the death certificate be executed te has been signed by the ettending physician and tage 2 should be detached for use as the burial-transit	Physician/Medical		Pregnant at time of death 5 Unknown	Other (specify)			World	Day Toal
Ф	res that the de signed by the c be detached t	by Ph	Part II. Other significant conditions contribution	g to death but not resulting in the	underlying cause giv	en in Part I.	23e. Did toba	cco use contribute to	the cause of death?
Records,	en signally	ed b	Chronic OBST	ructive Cy	ny ou	SEARC	1 Yes	2 □ No 3 □ Pr	obably 4 Unknown
eco	law requ as been 2 should	Completed			)		24a. Was an autopsy	prior to d	topsy findings available completion of cause of
		Соп					performe 1 ☐ Yes 21	death?	2 No
Vital	Physicien: The this certificate ral director, page	Be c	25. Was case referred to medical examiner?  1 \( \text{Yes} \) 2XX\( \text{Vo} \)	1 Discovings 2 DEB/Output	Oth	er:		ce 6 ☐Other (Spec	24.1
of		n; To	27. Manner of Death 28a.	1 ☐ Inpatient 2 ☐ ER/Outpati Date of Injury 28b. Time (Month, Day Year) Injury	of 28c. Injur		28d. Describe how		энуу
ion	Attending For death.  actor: After by the funer.	atlo	1 Natural 5 Pending investigation	(Month, Day Year) Injury		Yes 2 □ No			
Division	i Zi fi	Certification;	3 Suicide 6 Could not be determined 28e.	Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office		28f. Location (Stre City or Town,	et and Number or Ru State)	iral Route Number,
	To the Hospitel or Attend within 24 hours after death ) To the Funerel Director: completely filled in by the	edical C	(Check only Medical Examiner: On	To the best of my knowledge, de the basis of examination and/or d manner stated.					
	within To the compl	Me	29b. Signature and title of certifier		29c. Licens		290	I. Date signed (Mont)	n, Pay, Year)
) ,	Q.A.		1 Tabica L	my was	2 04	1728		4/12	105
	0		30. Name and address of person who completed Patrick Cross ST. Ma	ary's Hospital,	Leonardto	own, MD		1 1	70 VIII
	Sta Regist	ate rar	31. Date filed (Month, Day Year) 1 3 200	32. Register's Signature	Book				

State of Maryland / Department of Health and Mental Hygiene

				Otate of IVI	,	-	ificate	of Death	7		eg. No.2	0.5	1 0	361.6
			1. Decedent's Name (First, Middle, Las						2.	Date of Deet Month		Year	3. Tim	e of Death
	Physicial /Medica		George 1	2. Pie	rce	2				04		05	03	25
	Examine		4a Fecility Neme (It not institution, give	street end number)				4b. City, T	own, or Locat	tion of Deeth	4c. County			
			Lorien Assist	ed Livi	ng			Mt.	Airy,	MD		-ro/	<u> </u>	
	Funeral		Social Security Number     6. Security Number			st birthdey)	If Under 1 Months	Year If Unde Days Hours	Min. 8.	Date of Birth (Month, Dey.	Year)	9. Birthpl Coun	ace (Statry)	te or Foreign
	Director		210-20-0011	M 2□ F	80	Yrs.				05/28/	1924 V	lashi	ngto	n, DC
	p k	-	Usuel Residence of Decedent  10a. State 10b. County		10c City	Town or Loca	ition					10	Od. Inside	e City Limits
	aho aho	2	61 59%											res 2 □ No
	N S S	Director	Maryland Carroll  10e. Street end Number		Mt.	Airy	10f. Zip C	`ada		1	0g. Citizen of V	/het Coun	trv?	
	The state of	ᡖ					2177			US		mot oour		
	e 23	Funerai	713 Midway Avenue	12. Was Decedent	Ever in 11 S	13 W			rigin? (Specif			- Americ	an Indiar	),
	ar de	5	11. Maritel Status  1 ☐ Never Married 2 ☐ Merried	Armed Forces?		If '	res, specif	nt of Hispanic O y Cuban, Mexica	an, Puerto Rio	can, etc.)		k, White,		
20	rs af	گر آ	3 Widowed 4 Divorced	1 ☑ Yes 2 ☐ i If Yes, Give Year or Detes:	43-14	45	Yes 2	No Specify	<b>y</b> :		Specify	Whi	te	
21215-0020	within 72 hours aftar death with the Maryland ene. then "natural", or items 23a or 28a-f ahow ite Medical Examiner must be notified at	8	15. Decedent's Ed	ucation		16e Decede	nt's Usual	Occupation			16b. Kind of Bu			
5	ni o	Completed	(Specify only highest gre Elementery/Secondary (0-12)	de completed) College (1-4or :	54)	(Give ki life. Do	nd of work O NOT use	done during mo retired)	st of working					
212	with the state of	E	11	Conage (1-40)	,+,	Steam	Fitte	er		5	Steam F:	Ltter	Loc	al 602
b	offie officert,	Bec	17. Fether's Neme (First, Middle, Last)					18. Moth	ner's Name (F	First, Middle, I	Maiden Sumam	e)		
<u>a</u>	Aenta Aenta rked tlc e	١٩	Harry Allman Pier	ce				Cath	nerine	Elizat	eth Re	ed		
Maryland	am a	-	19a. Informent's Name/Relationship (7	ype, Print)				Street and Numb					Code)	
Σ	alth alth 27 le		Michael R. Pierce	/ Son				ing Stre	eet Roo					
Ze	of He		20a. Method of Disposition 1 ☐ Burial 2 🖾 Cremation 3 ☐	Dameual from State	20b. Pla	ace of Disposi metery, crema	tion (Name atory or oth	e of ner place)	ŀ	Date	20c. Location -	City or To	wn, State	9
Baltimore,	permit. Peges 1 end 2 should be filed within 72 hours aftar death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is merked other than "natural", or frems 23s or 28s-f show any Injury or other traumetic event, the Medical Examiner must be notified at once.		4 □ Donation 5 □ Other (Specify		Hun	tt Cre					Waldorf			
alti	partn Ports y Inje		21. Signature of Funeral Service Licen	599		22.	Name end	Address of Faci	lity Rober	rt E. I	Evans F	ınera	.1 Hc	ome
$\mathbf{\alpha}$	Depe Impo		16-121	7		160	000 A	nnapolis	s Road	Bowie	, MD 20	715		
		$\dashv$	23a. Pert1. Enter the diseese, or comp shock, or heart failure. List only	lications that cause	the death.							-	Approxi	mate Between
100	Physician		SHOOK, OF HEALT IANUTE. LIST ONLY	one cause on eeon a								1	Onset a	nd Death
	/Medical		Immediate Ceuse (Final disease or condition	CAN	685	TIVE		HEART	( FA	1 LUN	6	1	3 1	non
4.	Examiner		resulting in death)	a		as e consequ								
	p =	edicai Examiner		Cono	NAN	A	NZEF	vd Di	SEA	SE		1	0	LEARS
	requires that the death certificeta be executed een signed by the ettending physician and hould be datached for usa as the bunal-transit	Cam	Sequentially list conditions,	U	Due to (or	es e consequ	ence of):							
68760,	cian s	Ê	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury	c										
87	seta l	Q Q	that initieted events resulting in death) Last		Due to (or	es e conseque	ence of):					1		
9 ×	ling page as	Me		d										
Вох	ath c strenc for us	ä												
Ö	ires that the death cer signed by the ettendir d be datached for usa	Physician/M	Part II. Other significant conditions of	entributing to death b	ut not resu	Iting in the und	derlying car	use given in Parl	t I.		bacco use cor			
P.0	hat the sed by datac	£								1 □ Y	es 2t No	3∐ Prot	bably	4 □ Unknown
Records,	sign d be	ğ								24a. Wes e	en eutopsy	24b. We	ere autop	sy findings
Ö	e law require has been sig ge 2 should b	Completed								perfor		ava	ailable pr mpletion	of cause
Še	has b	d E									-		deeth?	.00
a	cate	ပိ									es 2 No	11	Yes	2LTN0
Vital	Iclan Sertifi ector	Be	25. Was case referred to medical examiner?	Hospital:				Other	_	Check only or			,	
ō	hysi al dir	္ရ	1 ☐ Yes 2 ☑ No 27. Menner of Deeth	1 L Inpati		28b. Time of		421			ence 6 Oth		y)	
5	Ing IIng After fune	5	1 ☑Naturel 5 ☐ Pending	28a. Date of Inju (Month, De	y Year)	Injury	м	3c. Injury et Work? 1 ∐ Yes 2 [						
Division	death death tor: / the	Cal	3 Suicide 6 Could not be		iurv - At hoi	me. farm. stree				f. Location (S	treet end Numb	er or Rure	/ Route /	Number,
Şi	or A after Direction by	E	4 ☐ Homicide determined		c. (Specify					City or Tow	n, Stete)			
	To the Hospital or Attending Physician: The is within 24 hours after death. To the Funeral Director: After his certificate ha completely filled in by the funeral director, page	edical Certification	29a. Certifier 1 Certifying Ph	rsician: To the best	of my know	vledge, deeth	occurred e	t the time, date a	and place, and	d due to the c	ause(s) and ma	nner as s	tated.	-1.
	Fur fetely	9	(Check only 2 Medical Examone)	Iner: On the basis of	f examinati	ion and/or inve	estigation, i	in my opinion, de	ath occurred	et the time, d	late and place,	end due to	the cau	se(s)
	Nithin To the comp	ž	29b. Signature end title of certifier				29c.	License number	r		29d. Date signe		-	ar)
			<b>V</b>	elno			D	>-31912	_		4102	105		
		ł	30. Name end eddress of person who		deeth (Item	23e) (Type, P								
			Julio MENOCA . PD	122090 POE	untol	UN PIU	4. 8	MEDERI	cu, m	1 51.	702			
			31. Date filed (Month, Day, Year)	32. Regi			-							

			4 101	rtment of Health and Ment	al Hygie	Ph Ph Ph Ph Ph	201.7
	Dévesie:		Decedent's Name (First, Middle, Last)		ate of Death	3.	Time of Death
	Physici /Medio		John Alden Randall			5, 2005	830A <sup>M</sup>
	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
				St. Leonard		Calvert	
r	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 6. Sex 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 6. Sex 7. Age (In yr	Months Days Hours Min. (M	ate of Birth fonth, Day, Ye		(State or Foreign
			Usual Residence of Decedent	Mā	ay 19	1935 Massa	achuette
	nylane how	. 1	10a. State 10b. County 10c. City, Town or Loc Maryland Calvert St. Leo			10d. li	nside City Limits
	Se-fa	cto	be. Heo	naru		1	☐Yes 2☐Xo
	vith th	Director	10e. Street and Number 1517 Avenue D	10f. Zip Code 20685	_	Citizen of What Country?	
	filed within 72 hours after death with the Maryland Hyglene. ther than "natural", or liems 23a or 28e-f ahow int, the Medical Exambar must be notified at	Funeral				nited State	
<b>'</b>	fter d	Fun	Armed Forces?	as Decedent of Hispanic Origin? (Specify Y Yes, specify Cuban, Mexican, Puerto Rican,	es or No- , etc.)	14. Race - American In Black, White, etc.	idian,
93	ursa al', o	by	1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 No 11 Yes, Give 2 No 11 Yes, Give 12 No 12 N	□Yes 2🙀 No Specify:		Specify: whit	te
21215-0036	72 ho natur	Completed	15. Decedent's Education 16a. Decede (Specify only highest grade completed) (Give k	int's Usual Occupation	16b	. Kind of Business/Industr	У
2	nen "	nple	Elementary/Secondary (0-12) College (1-4or 5+)	ind of work done during most of working O NOT use retired)			
2	iled w tygiei her tl nt, th		12 2 maste	r chief/ Seabees		Navy	
auc	ad of	Be	Leon Randall	18. Mother's Name (First		ansburg	
Maryland	should nd Me mark matic	2	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing	Address (Street and Number or Rural Rout	a Number Ci	ity or Town State Zin Cod	o)
<sub>ω</sub>	nd 2 statth ar 27 is rtrau			Ave. D. St.Leonar			
ē,	s 1 al f Hea itam othe			tion (Name of atory or other placeApril 7 20	00 E 200	Location - City or Town, S	
Ë	Page nent o nt: If		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  4 ☐ Donation 5 ☐ Other (Specify) Metropol	itan Funeral Serv	zice <sup>Al</sup>	exandria N	/irginia
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f ahow any injury or other traumatic avant, the Medical Examinational be notified at ance.		71	Name and Address of Facility	100		
_	99 E 2 9		13 Kaus 44			neral Home	MD 2067
П	#3		23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.			Inte	rvai Between
,	Physician		Immediate Cause (Final disease or condition coulting in double)	TRUCTIVE PULMON	UARY.	DISEASE Ons	et and Death
	/Medical Examiner		resulting in death)  Due to (or as a consequence of):				
		ē	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):				
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury				
ó	an an rial-tr	Exa	resulting in death) Last  C.  Due to (or as a consequence of):				
8760,	cate be executed oblysician and the burial-transit	dical	d				
$\widetilde{\mathbf{Q}}$	artifica ing ph e as t	Med	IF FEMALE:				
Вох	The law requires that the death certific tte has been signed by the attending pi vage 2 should be detached for use as t	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 □ Live birth 2 □ Fetal death 3 □ E	ctopic pregnancy		23d. Date of delivery Month Day	Year
P.O.	res that the de signed by the a be detached f	yslc	1	Other (specify)			
ď.	that the ded by detail		Part II. Other significant conditions contributing to death but not resulting in the unc	erlying cause given in Part I. 23	3e. Did tobacc	o use contribute to the cau	use of death?
ds	luires n sign lid be	d by	PERIPHERAL VASCULAR BIS		1 Yes	2 No 3 Probably	4 Unknown
Ö	w requires been si should?	lete		24	la. Was an	24b. Were autopsy fi	ndings available
Re	rsician: The law s certificate has b director, page 2 s	Completed			autopsy performed	prior to completi	on of cause of
ţ		BeC	25. Was case referred to medical	26. Place of Death (Chec		No 1 ☐ Yes 2 ☐ I	NO
>	ysica nis ca direc	ToE	examiner?  1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient	Other		6 ☐Other (Specify)	
Division of Vital Records,	ittanding Phy death. stor: After this the funeral o		27. Manner of Death 1 ✓ Natural 5 ☐ Pending (Month, Day Year) 28b. Time of Injury (Month, Day Year) 28b. Time of Injury			njury occurred	
Sio	tandi leath. tor: A the fu	catl	2 Accident investigation	M 1 Yes 2 No			
$\leq$	ra ra b)	Certification:	4 Homicide determined 28e. Place of Injury - At home, farm, stree building, etc. (Specify)		cation (Street ty or Town, St	and Number or Rural Rou ate)	te Number,
_	poital burs a laral (		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death of	Description of the time data and place and du	a to the server		
	24 hos 24 hos e Fun etely	edical	(Check only one)    Check only one   2   Medical Exeminer: On the basis of examination and/or investigation and manner stated.	stigation, in my opinion, death occurred at the	ne time, date	and place, and due to the c	cause(s)
	To tha Hospital or At within 24 hours after of To the Funaral Diract completely filled in by	Me	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month, Day,	Year)
)			rtty mm	040370	4	15/05	
			30. Name and address of person who completed cause of death (Item 23a) (Type, Pr	int)			
10	)+1		Peter Wisniewski, MD HOspital	Rd. Prince Fred	erick	MD 20678	
	Sta Registra	te	Peter Wisniewski, MD HOspital  31. Date filed (Month, Day PR 0 7 2005) Mayer M	Angell a			
	negistr	.10	A LEGILLET SC.	Stores			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Dav Vear **Physician** Rosenblum William 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Montgomery Rockville Washington Hebrew Home If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, July 2 9. Birthplace (State or Foreign Country)
Poland 7. Age (In vrs. last birthday) 5. Social Security Number **Funeral** 19001[XM 2□ F 104 Director 144-01-1095 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City. Town or Location 10d. Inside City Limits 10a State 10b. County in than "natural", or items 23a or 28a-f show the Madical Examiner must be nutified at 1 X Yes 2 No MD Montgomery Rockville Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 6121 Montrose Road #52B 20852 Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ZNo 1 □ Never Married 2 □ Married White 1 Yes 2 No Specify: Specify: If Yes, Give Year or Dates: 3 XWidowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Yiddish Culture Teacher 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Rachel Goldberg Louis Rosenblum ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7460 Red Bay Place Coral Springs, FL 33065 item 27 i Rabbi Leon Rosenblum/ Son 20b. Place of Disposition (Name of cometery, crematory or other place)
Beth David Cemetery 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once. 1 Burial 2 □ Cremation 3 □ Removal from State 4/4/2005 Elmont, New York \*4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Road Bowie, MD 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician Coronary disease or condition resulting in death) /Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the attending physician and hed for use as the burial-transit requires that the death certiticate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23a. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 1 ☐ Yes 2 ☐ No 2-No 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No his 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Hospital or Attending P 24 hours after death. Funeral Director: After the Certification: After 1. Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 24 hours a 1 Pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical To the Hosp within 24 ho To the Fune completely ti

State Registrar (Check only one)

6/05 31. Date filed (Month, DayAPR

29b. Signature and title of certifier

Denduck.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2005

Baltimore, Maryland 21215-0036

Box 68760.

P.O. |

Records,

Vital

Signature

29c. License number

0:44907

CONSUE LO

WCKN'LLE

29d. Date signed (Month, Day, Year)

Munice,

1, 2005-

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. I. Decedent's Name (First, Middle, Last) 2. Date of Death 8. Time of Death April 5, Day 2005 Year **Physician** Annette Beverly Sullivan 8:51 р м /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery 6207 Cromwell Drive Bethesda If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Nov. 16, 1915 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. New York 1□ M 2□ F 89Yrs. Director 057.03.3368 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ?7 is marked other than "natural", or Itams 23a or 28a-f show traumatic event, it is Medical Examinar must be notified at Director 1 ☐ Yes 3√☐ No Bethesda MD Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 20816 6207 Cromwell Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 No Specify: ģ 3 ☑ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Many injury or other traumatic event, the Many injury or other traumatic event, Elementary/Secondary (0-12) College (1-4or 5+) Own Home 12 Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Anne Lord Edward Connor ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18912 Rolling Acres Way Olney, MD Gene Sullivan/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State April 28,2005 Arlington, VA Arlington Nat. Cem. ' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funer Sepvice Licensee 22. Name and Address of Facility Joseph Gawler's Sons, 5130 Wisconsin Avenue NW WDC 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or beart failure. List only one cause on each line. Approximate Interval Between Onset and Death years Immediate Cause (Final 20 Priysician Hypertensive Cardiovascular Disease disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine certificate be executed the attending physician and hed for use as the burial-transit Due to (or as a consequence of): Box 68760 lan/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery requires that the death 3 Ectopic pregnancy in the past 12 months? Day 4 Pregnant at time of death Physic 5 Other (specify) Division of Vital Records, P.O. detached 9 Unknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2X No 3 Probably 4 Unknown pleted 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an The law has autopsy performed? Com certificate 1 ☐ Yes **X**□ No 1 TYAS 2 No : After this certification of the transfer of Hospital or Attending Physician: 25. Was case referred to medical graminer? Be 26. Place of Death (Check only one) Yes 2 No Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pendina r death. 1 ☐ Yes 2 ☐ No M investigation 2 Accident To the Hospital or Attenwithin 24 hours after deat 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 🗌 Homicide 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c, License number D0023592 April 7, 2005 anthony ervel 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5530 Wisconsin Avenue #1400 Chevy Chase, MD Anthony J. Corvelli, M.D. 31. Date filed (Month, Day, Year) APR 0 8 2005 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 15

		-	For State Registrar	State of Maryl		artment of H rtificate of L			Reg. No.	13650
ı			1. Decedent's Name (First, Middle, Las	t)				2. Date of Dea Month	ith Day Year	3. Time of Death
	Physicia /Medic		Elizabeth Ann Sc	huster				April_	6 2005	05:40 A M
	Examin		4a. Facility Name (If not institution, give	street and number)			Location of Death		4c. County of Dea	
			8505 Cunningham D		1 - 1 t t - 1 t - 1	Berwyn H		O Data of Birth	Prince G	
	Funeral Director		213-66-3440	ox	yrs. last birthday) Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day July 15	Year) 1952 Was	rthplace (State or Foreign owntry) Shington, DC
	ryland how		Usual Residence of Decedent  10a. State 10b. County	100	. City, Town or Lo	ocation				10d. Inside City Limits
	Be-f s	Director	MD Prince G	George's B	erwyn He					1 Yes 2 □ No
	or 28	Dire	10e. Street and Number			10f. Zip Code			10g. Citizen of What C	ountry?
	s 23e	ra	8505 Cunningham I	)rive 12. Was Decedent Ever	in II 9	20740	icagaio Origin? (Sa	acify Vas or No-	USA 14. Race - Am	erican Indian
36	be filed within 72 hours after death with the Maryland ital Hyglene. d other than "netural", or flems 23a or 28e-f show event, the Madical Examinar must be notified at	by Funeral	11. Marital Status  1 ★ Never Married 2  Married	Armed Forces?  1 ☐ Yes 2 X No If Yes, Give Year or Dates:		Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2X No	Specify:	Rican, etc.)	Black, Wh	ite, etc.
Maryland 21215-0036	hour tural	d be	3 ☐ Widowed 4 ☐ Divorced  15. Decedent's Ed		16a Dece	dent's Usual Occupa	ation		16b. Kind of Busines:	Thite s/Industry
5	in 72 in 8	Completed	(Specify only highest gra-	de completed)	(Give	kind of work done of DO NOT use retired	during most of work ()	ring		,
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ַ		ВеС	17. Father's Name (First, Middle, Last)				18. Mother's Name	e (First, Middle,	Maiden Sumame)	
ā	ould be Mental Arked o	To E	Joseph H. Schust	er			Ann Eli	zabeth ]	Brannen	
an	es 1 and 2 should be of Health and Mental fitem 27 is marked or r other treumatic eve		19a. Informant's Name/Relationship (7	Гуре, Print)					r, City or Town, State,	
	and 2 ealth n 27 i		Kathleen Schuster						Heights,	
altimore,	Pages 1 nent of Hi int: If iter	. 1	20a. Method of Disposition 1  ☐ Burial 2 ☐ Cremation 3 ☐	Removal from State	cemetery, crei	osition (Name of matory or other place	I	Date	20c. Location - City o	r Iown, State
Ē	Pag tment tent: jury d		4 ☐ Donation 5 ☐ Other (Specify	)		Heaven Ce			Silver Spr	
Ball	permit. Page Department of Importent: If any injury or once.		21. Signal of Funeral Service Licen						neral Home ttsville,	
	Ъ.		23a. Part1. Enter the disease, or comp shock, or heart failure. List only	olications that caused the one cause on each line.	death. Do not ent	ter the mode of dyin	g, such as cardiac	or respiratory ar	rest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	a Glomas Tu	mors					Onset and Death
Ġ.	/Medical		resulting in death)	Due to (or as a co						
L	Examiner		Sequentially list conditions,	b. Pheochnor	nocytoma					
	pe tis	ine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a co	nsequence of):					
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68760,	ficate phys s the	edical		. d						
Вох	The law requires that the death certificate has been signed by the attending I page 2 should be detached for use as	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No	23c. If yes, outcome of pr 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time	Fetal death 3	□Ectopic pregnancy □ Other <i>(specify)</i>	/		23d. Date of di Month	elivery Day Year
P.O.	at the 1 by th etach	Phy	9 🗆 Unknown		A 161 1- 16		and in Daniel	22a Did to	ahaasa usa santsihuta	to the cause of death?
	w requires the been signed should be d	ed by	Part II. Dther significant conditions of Hypertension	ontributing to death but no	it resulting in the d	indenying cause giv	en in racti.			Probably 4 Unknown
Reco	ne law requ nhas been ge 2 shoul	Completed	Rothmund-Thompson					24a. Was autop perfor	rmed? prior to death?	
a		e Co	Tracheostomy for 25. Was case referred to medical	Dysphagia			26. Place of Deal			s 2 No
5	Physicien: this certificated all director, is	To B	examiner? 1 ☐ Yes 2 ☒ No	Hospital: 1 ☐ Inpatient	2 ☐ ER/Outpatie	nt 3 DOA Oth	ar		dence 6 □Other (Sp	ecify)
ou of	ding F. After fune		27. Manner of Death 1 🕅 Natural 5 🗆 Pending 2 🗀 Accident investigation	28a. Date of Injury (Month, Day Ye	28b. Time o	of 28c. Injur Wor	y at		now injury occurred	,,
Division of Vital Records,	in the	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - building, etc. (S	At home, farm, st pecify)	reet, factory, office		28f. Location (S City or Tox	Street and Number or I vn, State)	Rural Route Number,
	e Hospitel 24 hours a e Funerel l letely filled	edical C		ysician: To the best of miner: On the basis of exa						
	To the l within 2 To the l	Med	29b. Signature and title of certifier			29c. Licens	e number		29d. Date signed (Mor	nth, Day, Year)
			Tyme	660		$\Rightarrow$ D34	472		April 6,	2005
R	$\left(2\right)$		30. Name and address of person who	completed cause of death		Print)		n, Marv		
	Sta Regist	ate rar	Lynne Diggs, 104 31. Date filed (Month, Day, Year)  APR 0 8 200	Registrar's	Signature	W				

Michael Carlson Stone Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 05-02310 State of Maryland / Department of Health and Mental Hygiene RPD Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** MICHAEL CARLSON STONE <u> April</u> 2005 2350 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Trappe Beaver Dam Road @ Route 50 <u>Talbot</u> If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) MAY 3 1988 Year 5. Social Security Number 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** Days Hours Months 1 X M 2 □ F MARYLAND 216-25-8385 16 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Examiner must be notified at EASTON 1X Yes 2 □ No TALBOT MD Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ŏ **HZII** 21601 or Items 23e 352 GLEBE ROAD Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: WHITE Š 3 Widowed 4 Divorced "natural" Completed The Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) HIGH SCHOOL STUDENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be and Mental Is marked of permit. Pages 1 and 2 should be Department of Health and Mental Importent: If item 27 is marked cany injury or other treumatic eve 90s8. RUSSELL STONE, JR. SHELLY SMITH ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RUSSELL STONE, JR./FATHER 352 GLEBE ROAD, EASTON, MD 21601 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State CHESAPEAKE CREMATION CTR. 4-3-2005 STEVENSVILLE, MD 14 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST EASTON, MD 21601 JOHN R. MERCEROR 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MULTIP DWUNG Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospitel or Attending Physicien: The law requires that the death certificate be executed burial-transil Due to (or as a consequence of): Box 68760, attending physician Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetaf death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ page 2 should be 2 No 3 Probably 4 Unknown 1 Tyes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 res 2 No autopsy performed? 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other 4 Nursing Home 5 Residence 6 Cher (Specify) at Scene 1 XYes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 🖾 No 23:40°M PRIVER OF CARIMPISET KITITRET after death. 6 Could not be determined 3 🔲 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of firury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide RODANDY BEAUGR DOMPOGRTTO TOLISOTED MY 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

2 State

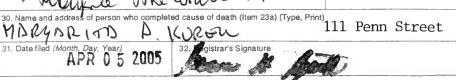
Registrar

within 2. To the f the

> MARGARITA APR 0 5 2005

(Check only one)

29b. Signature and title of certifier



29c. License number OCME

29d. Date signed (Month. Dav. Year) April 2, 2005

Baltimore, Maryland 21201

	1.	Registrar Decedent's Name	(First, Middle,	Last)			rtificate	JOIL	Juan		2. Date of De		600	J	3. Time of Death
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ner	4a.	Facility Name (If r					4b. City, 7	Town, or	Location of	of Death	•	1	County of D		
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		a. State	Decedent 10b. County		10c. Ci	ty, Town or L	ocation							100	d. Inside City Limits
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Funeral Director	10	e. Street and Numb					10f. Zip	Code				10g. Cit	izen of Wha	t Countr	y?
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To Be		MICHAEL .			N						AN ROBI				
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		JUNE C.	SULLIV	AN/WIFE		_			AVE.	-	STON, M				= )
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	1 - State Registrar	ate of Maryland / Dep Ce	artment of Health and rtificate of Death		g. No.	13653
Physician	Decedent's Name (First, Middle, Last)     Robert Edison Stee	le		Month April 16	Day 2005	3. Time of Death 4:10 A. M
/Medical Examiner	4a. Facility Name (If not institution, give street	and number)	4b. City, Town, or Location of De		4c. County of Death	1320 110
Examiner	Southern Maryland Hospita	a1	Clinton		Prince Geor	rge's
Funeral Director	5. Social Security Number 6. Sex 1 🖫 M	7. Age (In yrs. last birthday) 2 F 55 Yrs.	If Under 1 Year If Under 24 H Months Days Hours Mi			elace (State or Foreign etry) inia
<b>*</b> 2.5	Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Le	ocation		1	Od. Inside City Limits
nal Hygiene.  d other then "natural", or items 23e or 28e-f show event. The Medical Examiner must be notified at Be Completed by Funeral Director						1 ☐ Yes 2 No
or 28e-f e be notifie Director	Maryland St. Mary's  10e. Street and Number	Callaway	10f. Zip Code	10	g. Citizen of What Coun	ntry?
39 o	20401 Jackson Road		20620		USA	
by Funeral	11. Marital Status 12. V 1 ☐ Never Married 2 → Married 1	☐ Yes 2 🗑 No	Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pur 1 ☐ Yes 2 ▼ No Specify:	(Specify Yes or No- erto Rican, etc.)	14. Race - Americ Black, White, Specify: White	etc.
Completed	15. Decedent's Education (Specify only highest grade con Elementary/Secondary (0-12)	noleted) (Give	dent's Usual Occupation kind of work done during most of w DO NOT use retired)	vorking	6b. Kind of Business/Ind	dustry
	12 17. Father's Name (First, Middle, Last)	Ca	rpenter 18. Mother's N	lame (First, Middle, Mi	Home Construct	ion
o Be	Burl Turner Steele			nia Jeanette		
2	19a. Informant's Name/Relationship (Type, F	Print) 19b. Maili	ng Address (Street and Number or			Code)
1	Vivian Beryl Troiano/Sist	er 20401	Jackson Road, Calla	way. Maryland	1 20620	
	20a. Method of Disposition  1  Burial 2  Cremation 3  Remove 4  Donation 5  Other (Specify)	20b. Place of Dispo cemetery, cre	osition (Name of matory or other place)	Date 2	Oc. Location - City or To	
once.	21. Signature of Funeral Service Licensee	diver	2. Name and Address of Facility M P. O. Box 270, Leona	attingley-Gar	diner Funeral	
an al er	23a. Part l.Enter the disease, or complication shock, or heart failure. List only one call mmediate Cause (Final disease or condition resulting in death)	ns that caused the death. Do not en use on each line.  Output  Due to (or as a consequence of):		iac or respiratory arres	st,	Approximate Interval Between Onset and Death
edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Entitle funderlying Cause (Disease or injury that initiated events resulting in death) Last  d.	Due to (or as a consequence of):  Due to (or as a consequence of):				
Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 9		□Ectopic pregnancy □ Other (specify)		23d. Date of delive Month	ry Day Year
b	Part II. Other significent conditions contribu	ting to death but not resulting in the u	inderlying cause given in Part I.		acco use contribute to the	
Completed				24a. Was an autopsy perform	prior to cor	osy findings available npletion of cause of 212 No
Be Com	25. Was case referred to medical		26. Place of D	eath (Check only one,	)	
2	1 □ Yes 2 ☑ No	tal: 1 ☑npatient 2 ☐ ER/Outpatien  Ba. Date of Injury (Month, Day Year)  28b. Time of Injury		Home 5 Residen	ice 6	v)
Certification:	a Could not be	Be. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (Stre City or Town,	eet and Number or Rura. State)	l Route Number,
Medical C	(Check only 2 Medical Examiner:	n: To the best of my knowledge, deat On the basis of examination and/or in and manner stated.				
Medical Certifi	29b. Signature and title of certifier		29c. License number	290	d. Date signed (Month, I	Day, Year)
	30. Name at a tress of person who comple	ejed cause of death (Item 23a) (Type	()00594	26 6	04/17/2	005
ソ	Riberd Yeckski	4 7503 Su	crafts Rd (	linken	Mary Jan	d
State legistrar	31. Date filed (Month, Day, Year)  APR 1 8 2	32. Register's Signature	Aparte .		/ '	

			1 - State of Marylan	nd / Department of Health and M Certificate of Death	Mental Hygiene	005 13654
	Physicia		1. Decedent's Name (First, Middle, Last) Lila	Shuebrooks	2. Date of Death Month Day March 20,	3. Time of Death 2005 12:40P M
	/Medic Examin		4a. Facility Name (If not institution, give street and number) Washington Adventist Hosp		4c. C M	ounty of Death ontgomery
	Funeral Director		5. Social Security Number 2 18 − 24 − 064 2 6. Sex 1 □ M 2 1 1 □ M 2 1 1 7. Age (In yrs. 75 1 1 □ M 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	last birthday) Yrs.  If Under 1 Year  If Under 24 Hrs.  Months  Days  Hours  Min.	8. Date of Birth Feb. 18, 19	9. Birthplace (State or Foreign Country) Maryland
	Maryland 9-f show	Ιġ	10a. State 10b. County 10c. Cit	ty, Town or Location Scotland		10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	th with the 23a or 28 ust be not	al Direc	Maryland St. Mary's  10e. Street and Number  49510 Gaslewbrooks Drive			on of What Country? USA
980	within 72 hours after death with the Maryland ane. than 'netural', or Itams 23e or 28e-f show than "and Examiter must be multied at	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U. Armed Forces?  1 Never Married 2 Married If Yes, Give Year or Dates:	I.S. 13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 No Specify:	Rican, etc.)	Black, White, etc.  Black Black  Black
21215-0036	J within 72 ho jiene. ir than "netui ir b wollcal	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  1 2  College (1-4or 5+) 4	16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)  Registered Nurse	ing	of Business/Industry
Maryland 2	be filed Ital Hyg Id other	To Be C	17. Father's Name (First, Middle, Last) Richard Whi		e (First, Middle, Maiden S. S.	<sub>umame)</sub> horter
	d 2 s th ar 7 la trau		19a. Informant's Name/Relationship (Type, Print) Bernice Taylor/sister	19b. Mailing Address (Street and Number or Run P.O. Box 174 Love	eville, MD	20656
Baltimore,	Pages nent of int: If it		1 X Burial 2 □ Cremation 3 □ Removal from State 1 □ Cremation 5 □ Other (Specify)	cometery, crematory or other place)  Luke UMC Cem. Mar.:	26,2005 S	ation - City or Town, State
Ba	permit. Departn Imports any inju		21. Signature of Funeral Service Licensee  John Grand	22. Name and Address of Facility States 1451 Dares Beact		ral Home ce Fred., MD2067
8760,	The law requires that the death certificate be executed as the law requires that has been signed by the attending physician and upper large 2 should be detached for use as the burial-transit	dical Examiner	Sequentially list conditions, Tarry, leading to mindulate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of injury that initiated events resulting in death) Last  Due to (or as a consequence of injury that initiated events resulting in death) Last  Due to (or as a consequence of injury that initiated events resulting in death) Last	mence ot):  Lipso  Mence pr):  Lipso   mi	Interval Batween Onset and Death	
P.O. Box 6	he death certific / the attending p ched for use as i	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼ No 9 □ Unknown  23c. If yes, outcome of pregnat 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	al death 3 Ectopic pregnancy	23	id. Date of delivery Month Day Year
Ś	w requires that the de been signed by the a should be detached f	by	Part II. Other significant conditions contributing to death but not res	sulting in the underlying cause given in Part I.	23e. Did tobacco use	e contribute to the cause of death?
Record	The law re ate has bee page 2 sho	Completed			24a. Was an autopsy performed? 1 ☐ Yes 2 △ No	24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No
Division of Vital	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funarel Diractor: After this certificate ha completely filled in by the funeral director, page	Certification; To Be	27. Manner of Death  1 Natural 5 Pending (Month, Day Year)  2 Accident investigation investigation	28b. Time of Injury Mork?  M 1 Yes 2 No  Other: 4 Nursing Ho Work?  M 1 Yes 2 No	h (Check only one) ome 5 ☐ Residence 6   28d. Describe how injury 28f. Location (Street and City or Town, State)	
	the Hospita thin 24 hours the Funarel mpletely filled	Medical C		owledge, death occurred at the time, date and place, ation and/or investigation, in my opinion, death occur	red at the time, date and p	
	T V VIII		30. Name and address of person who completed cause of death (Iten	56/4	7 4-1	-05
	5 Sta	ate	Nasreen Kango, M.D.	7610 Carroll Avenu	e Tak	oma Park,MD2091
	Regist	rar	31. Date filed (Month, Day, Year)  APR 0 4 2005	a St Goales		

			1 - For State Registrar		epartment of Health and N Certificate of Death	Mental Hygie	2000	100000
			Decedent's Name (First, Middle, Last)			2. Date of Death	the same and the s	3. Time of Death
н	Physici /Medic		Ethel Lurine	e Stinson		April 3,	2005 Year	6:45 p M
	Examin		4a. Facility Name (If not institution, give s	treet and number)	4b. City, Town, or Location of Death		4c. County of Death	
			650 Alder Place	7 4 (1 (2-4-1-1-4)	Rose Haven  If Under 1 Year   If Under 24 Hrs.	10.00-10.00	Anne Arun	
	Funeral Director		5. Social Security Number 6. Sex	N 377 F	Months Days Hours Min.	8. Date of Birth (Month, Day, Ye Nov. 29, 1	ear) 9. Birthi Cou	place (State or Foreign ntry) LESOta
	ש		334-24-9198 Usual Residence of Decedent			1100 . 29	IJZJ MILIII.	esoca
	show	_	10a. State 10b. County	10c. City, Town				10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	he M	ecto	Maryland Anne Arund	let Rose	Haven	10-	Citizen of What Cou	
	with With Leep	פֿיַ	650 Alder Place		20714	Tog.	U.S.A	
	death ms 23	nera		12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? (Sp	pecify Yes or No-	14. Race - Ameri	can Indian,
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural', or Items 23a or 28a-f show any injury or other traumatic event, I'm Medical Evarified mintal te ficilified at angles.	by Funeral Director	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give	If Yes, specify Cuban, Mexican, Puerio	Hican, etc.)	Black, White,	
Ö	hour tural		3 ₩ Widowed 4 □ Divorced  15. Decedent's Educ	Year or Dates:	Decedent's Usual Occupation	166	. Kind of Business/In	nite
715	in 72	Completed	(Specify only highest grade Elementary/Secondary (0-12)	completed)	Give kind of work done during most of work life. DO NOT use retired)	king		
212	giene giene er the	Com	12		homemaker		own hom	e
Maryland 21215-0036	be file tal Hy d oth event	Be	17. Father's Name (First, Middle, Last)			e (First, Middle, Maid	den Sumame)	
Z	d Men narke	L O	Malker Fangst		Mable Mailing Address (Street and Number or Rui	Toppir		- Codo)
Mai	d2st than than 7 Is n traun		19a. Informant's Name/Relationship (Ty) Charles Gallimore,					
ē,	s 1 an F Heal item 2 other		20a. Method of Disposition	20b. Place of	1 Fishers Station Red Disposition (Name of crematory or other place)		Location - City or To	
OL	Pages ent of nt: If i		1 ☐ Burial 2 ☐ Cremation 3 ☐ R 1 ☐ Donation 5 ☐ Other (Specify)		olitan Crematory 04,	/04/2005 A	lexandria	, VA
Baltimore,	permit. Departm Imports any inju		Signature of Funeral Service L. ense	90	22. Name and Address of Facility			
<u> </u>	99 = 9		Duya 11	erbach	Rausch Funeral Home		Wings, MD	20736
г			shock, or fear failure. List only on	cations that ceused the death. Do not be cause on each line.	ot enter the mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death
	Physician /Medical	8 8	Immediate Cause (Final disease or condition resulting in death)	Liver can	cer			6 months
	Examiner			Due to (or as a consequence o	f):			
		Jer	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence o	r):			-
	icate be executed physician and the burial-transit	Examine	cause. Enter Underlying Cause (Disease or injury) that initiated events					
Ö,	certificate be executed adding physician and use as the burial transit	I Ex	resulting in death) Last	Due to (or as a consequence or	f):			
8760,	cate b physic the b	dical						
9 x	certifi ding se as	/Me	IF FEMALE:	3c. If yes, outcome of pregnancy			23d. Date of delive	arv
Box	ath	by Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		Month	Day Year
P.0	by the	hys	9 Unknown	9∐ Unknown				
Ś	Se Dec		Part II. Other significant conditions con	tributing to death but not resulting in	the underlying cause given in Part I.	23e. Did tobacc	co use contribute to the	
orc	w requires been sign should be	eted					/	
Vital Record	e la has	Completed				24a. Was an autopsy performed	prior to co death?	ppsy findings available mpletion of cause of
[a]		e Co	25. Was case referred to medical		26 Place of Dea	1 ☐ Yes 2	No 1 □ Yes	2 No
	S 0 0	ToB	examiner?	lospital: 1 ☐ Inpatient 2 ☐ ER/Out	Othon		e 6 ☐Other (Specif	(v)
0	iding Physith.		27. Manner of Death  ↑ Selatural 5 ☐ Pending	28a. Date of Injury (Month, Day Year) 28b. Ti		28d. Describe how in	njury occurred	.,
Sio	Attending or death. ector: After by the fune	catic	2 Accident investigation 3 Suicide 6 Could not be		M 1 Yes 2 No	ant to the		
Division of	l or Attendation of the death Director:	ertification;	4 Homicide determined	28e. Place of Injury - At home, fan building, etc. (Specify)	m, street, factory, office	City or Town, Si	t and Number or Rura tate)	al Houte Number,
	To the Hospital or Attenwithin 24 hours after deatl To the Funeral Director:	edical C	29a. Certifier 12 Certifying Phys	sician: To the best of my knowledge,	death occurred at the time, date and place, /or investigation, in my opinion, death occur	and due to the cause	e(s) and manner as s	tated.
	To the P within 24 To the F complete	Medi	29b. Signature and title of certifier	and manner stated.	29c. License number		Date signed (Month,	
)	¥ ¥ ¥ 8		· Ma 16	S ( W. A.A)	DEGNI	1 4	1/4/05	
	Έ.		30. Name and address of person who co	mpleted cause of death (Item 23a) (	Type, Print)	20 Prir	to Frank	erick, MD
_	5		Arati Date	1 110 HOSOHO	al Road Suite	39 ''"	0	10678
	Sta		31. Date filed (Month, Day, Year)	32. Registrate Signature	W 1			, ,
	Registi	ar		2005   Geneva	of Sparker			

Physici		Decedent's Name (First, Middle, Last)	State of Man Unpend Ite	&pt.110e/			2. Date of Deat		3. Time of Death
/R.# = -1:		Dolores	0.	Turano			Month April	Day Year 16. 2005	1:29 P M
/Medio Examin		4a. Facility Name (If not institution, give s		Turano	4b. City, Town, or	Location of Deat	<del></del>	4c. County of Death	
LAGIIII	101	University of Maryl		al Center	Balti	more		N/A	
Funeral		5. Social Security Number 6. Sex	7. Age (f.	In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,		nplace (State or Foreign
Director		5/7-56-8//9	M <sup>2</sup> F 63	Yrs.			1/9/19		ington,DC
and		Usuat Residence of Decedent  10a. State 10b. County	10	Oc. City, Town or Lo	ocation				10d. Inside City Limits
Maryland -f show	ō	Maryland Wicomico	,	Hebron					1 ☐ Yes 2X No
h the Marylan r 28a-f show s notified at	Director	10e. Street and Number		TICDEOIT	10f. Zip Code		10	g. Citizen of What Co	untry?
th with 23a or ast be		26812 Crossbill Co	ourt		21830	)		USA	
ge g	Funeral	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S. 13.1	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (S n. Mexican, Puerl	pecify Yes or No- o Rican, etc.)	14. Race - Amer Black, White	
or Ite	y Fu	1 Never Married 2 Married	1 ☐ Yes 2 XNo If Yes, Give		1 ☐ Yes 2 🖾 No	Specify:		Specify: Wh	
ed within 72 hours afi giene. er than "natural", or in the Medicel Exami	d by	3 Widowed 4 Divorced	Year or Dates:	16a Dana	donte Herel Ossus	-61			
in 72 "nai	lete	15. Decedent's Educ (Specify onfy highest grade	completed)	(Give	dent's Usual Occupa kind of work done of DO NOT use retired	during most of wor	king	6b. Kind of Business/I	ndustry
y with jiene. r than	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Sec:	retary			Public Sch	$\infty$ 1
should be filed within 72 hou with the filed within 72 hou as marked other than "natura numatic evant, ins Mccicil E	Bec	17. Father's Name (First, Middle, Last)				18. Mother's Nar	ne (First, Middle, N	laiden Sumame)	
uld by Menta Irked Itlc e	To E	Anthony Oliva				Te	resa Soc	dero	
		19a. Informant's Name/Relationship (Typ	oe, Print)	19b. Mailir	ng Address (Street a	and Number or Ru	ral Route Number,	City or Town, State, Z.	ip Code)
	1	Frank Turano/husbar			12 Corssb	ill Cour	t, Hebror	MD: 21830 oc. Location - City or 1	
permit. Pages 1 ar Department of Hes mportant: If item any Injury or othe		20a. Method of Disposition 1 ⊠Burial 2 □ Cremation 3 □ Re	I	-	matory or other plac	8)   1/2	1,0		
Pag tment tant: I		'4 □ Donation 5 □ Other (Specify)		Maryland	Veterans	4/2	2/2005	Hurlock, M	U
permit. Pages Department of Important: If it any Injury or once.		21. Sonature of Funeral Service License	20/		Name and Address	Funeral	Home Prof	essional A	ssociation 4
		22a. Part. Enter the disease, or complic	nations that used in						Approximate
Ite be executed ysician and ne burial-transit	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Disease or injury that initiated events resulting in death) Last	Due to (or as a co						
2 (0	Icai								
physi physi	0	d							
the death certificate the attending phyiched for use as the	ysician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No	3c. If yes, outcome of p 1 □ Live birth 2 □ 4 □ Pregnant at tim 9 □ Unknown	☐Fetal death 3☐	Ectopic pregnancy Other (specify)			23d. Date of deliv	very Day Year
uires that the death certificate in signed by the attending phy:	d by Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 \( \subseteq Yes \) 2 \( \subseteq No \)	1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim 9 ☐ Unknown tributing to death but n	Fetal death 3 [ne of death 5 [	Other (specify)	en in Part I.		Month acco use contribute to	Day Year
The law requires that the death certificate te has been signed by the attending phy; age 2 should be detached for use as the	ompleted by Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  Part II. Other significant conditions con	1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim 9 ☐ Unknown tributing to death but n	Fetal death 3 [ne of death 5 [	Other (specify)	en in Part I.	1 ☐ Yes 24a. Was an autopsy perform	Month  acco use contribute to s 2 \( \text{No} \) 3 \( \text{Pro} \) rote aut prior to c ed?	the cause of death?  bably 4 Aunknown  opsy findings available ompletion of cause of
an: The law requires that the death certificate tilicate has been signed by the attending phy. tor, page 2 should be detached for use as the	e Completed by	23b. Was decedent pregnant in the past 12 months?  1   Yes 2   No 9   Manknown  Part II. Other significant conditions con  Squamous Cell Carc  Complications  25. Was case referred to medical	1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim 9 ☐ Unknown tributing to death but n	Fetal death 3 [ne of death 5 [	Other (specify)	ent And	1 Yes 2	Month  acco use contribute to  s 2 \( \text{No} \) 3 \( \text{Prior} \) Prior to compare to contribute to  ad? \( \text{desito} \) 1355 ves	Day Year the cause of death? bably 4 Zunknown
ysticlen: The law requires that the death certificate is certificate has been signed by the attending phy: director, page 2 should be detached for use as the	Be Completed by	23b. Was decedent pregnant in the past 12 months?  1   Yes   2   No    9   Inknown  Part II. Other significant conditions con Squamous Cell Carc Complications  25. Was case referred to medical examiner?	1 Live birth 2 £ 4 Pregnant at tim 9 Unknown  tributing to death but n  inoma with	Fétal déath 3 [ne of death 5 [ne of death 5 ]	Other (specify)  nderlying cause give  Treatme	ent And	1  Yes  24a. Was an autopsy perform 1/2 Yes 2	Month  acco use contribute to s 2 \( \text{No} \) 3 \( \text{Pro} \) 24b. Were aut prior to cod? death? \( \text{No} \) 134 \( \text{Ps} \)	the cause of death?  bably 4 Aunknown  opsy findings available ompletion of cause of  2 \square No
ng Physician: The law requires that the death certificater this certificate has been signed by the attending princral director, page 2 should be detached for use as the	To Be Completed by	23b. Was decedent pregnant in the past 12 months?  1   Yes   2   No    9   Sunknown  Part II. Other significant conditions con  Squamous Cell Carc  Complications  25. Was case referred to medical examiner?  1   Yes   2   No    27. Manner of Death  1   Matural   5   Pending investigation	1 Live birth 2 £ 4 Pregnant at tim 9 Unknown  tributing to death but n  inoma with	Fetal death 3 ne of death 5 not resulting in the unit Extensiv	nderlying cause giver Treatment 3 DOA Other	26. Place of Dea	1  Yes  24a. Was an autopsy perform 1/2 Yes 2	Month  acco use contribute to s 2 \( \text{No} \) 3 \( \text{Pro} \) rior to c death? \( \text{No} \) No \( \text{No} \) 1 \( \text{Mere aut} \) rior to c death? \( \text{No} \) 1 \( \text{No} \) es	the cause of death?  bably 4 Aunknown  opsy findings available ompletion of cause of  2 \square No
ng Physician: The law requires that the death certificater this certificate has been signed by the attending princral director, page 2 should be detached for use as the	To Be Completed by	23b. Was decedent pregnant in the past 12 months?  1   Yes   2   No    9   Minknown  Part II. Other significant conditions con Squamous Cell Carc Complications  25. Was case referred to medical examiner?  1   Xes   2   No    27. Manner of Death   1   Xellong   Natural   5   Pending	1 Live birth 2 £ 4 Pregnant at tim 9 Unknown  tributing to death but n  inoma with	Pétal déath 3 ne of death 5 ne of death 6 ne	nderlying cause give Treatment 3 DOA Other	26. Place of Dea	24a. Was an autopsy perform 1/2 Yes 2 ath (Check only one 5 Resider 28d. Describe hor	Month  acco use contribute to s 2 No 3 Pro ed? No 1 Seves  contribute to s 2 No 3 Pro death? Ince 6 Other (Spec winjury occurred	the cause of death?  bably 4 Aunknown  opsy findings available ompletion of cause of  2 \sum No
ng Physician: The law requires that the death certificater this certificate has been signed by the attending princral director, page 2 should be detached for use as the	To Be Completed by	23b. Was decedent pregnant in the past 12 months?  1   Yes   2   No    9   Manner of Death  1   Natural   2   No    27. Manner of Death  1   Natural   2   Accident   3   Suicide   4   Homicide    29a. Certifier   1   Certifying Phys	1 Live birth 2 Live Pregnant at time 9 Unknown tributing to death but n inoma with  ospital: 1 Inpatient 28a. Date of Injury (Month, Day You	Pétal déath 3 ne of death 5 ne of death 6 ne	nderlying cause give Treatment 3 DOA Other (specify) —  at 4 DOA Other (specify) —  at	26. Place of Dea ar: 4 \( \triangle	24a. Was an autopsy perform 1/2 Yes 2 th (Check only one ome 5 Resider 28d. Describe how city or Town, and due to the ca	Month  acco use contribute to s 2 \( \text{No} \) 3 \( \text{Prior to c} \) death?  ad?  ad?  ad?  ad?  ad?  by injury occurred  aset and Number or Rui  State)	Day Year  the cause of death?  bably 4 Aunknown  opsy findings available ompletion of cause of  2 No  ral Route Number,
ng Physician: The law requires that the death certificater this certificate has been signed by the attending princral director, page 2 should be detached for use as the	Be Completed by	23b. Was decedent pregnant in the past 12 months?  1   Yes   2   No    9   Sunknown  Part II. Other significant conditions con Squamous Cell Carc  Complications  25. Was case referred to medical examiner?  1   Yes   2   No    27. Manner of Death 1   X Natural   5   Pending investigation   3   Suicide   4   Homicide   Global Physical P	1 Live birth 2 £ 4 Pregnant at im 9 Unknown  tributing to death but n  inoma with  28a. Date of Injury (Month, Day You  28e. Place of Injury building, etc. (sician: To the best of ner: On the basis of ex	Pétal déath 3 ne of death 5 ne of death 6 ne	nderlying cause give Treatment 3 DOA Other (specify) —  at 4 DOA Other (specify) —  at	26. Place of Dea	24a. Was an autopsy perform 1/2 Yes 2  th (Check only one ome 5 Resider 28d. Describe hor City or Town, and due to the carred at the time, da	Month  acco use contribute to s 2 \( \text{No} \) 3 \( \text{Prior to c} \) death?  ad?  ad?  ad?  ad?  ad?  by injury occurred  aset and Number or Rui  State)	the cause of death?  bably 4 Anknown  opsy findings available ompletion of cause of  2 No  ify)  ral Route Number,  stated.  to the cause(s)
Hospital or Attending Physician: The law requires that the death certifics 4 hours after death. A hours after death. He rector: After this certificate has been signed by the attending pf ely filled in by the funeral director, page 2 should be detached for use as the filled in by the funeral director.	To Be Completed by	23b. Was decedent pregnant in the past 12 months?  1   Yes   2   No    9   Minknown  Part II. Other significant conditions con Squamous Cell Carc  Complications  25. Was case referred to medical examiner?  1   Xes   2   No   H  27. Manner of Death 1   Matural   5   Pending investigation   28. Certifier   Check only one)  29a. Certifier   Check only one)  2   Medical Examination   Medical Examination   29a. Certifier   Check only one)	1 Live birth 2 £ 4 Pregnant at im 9 Unknown  tributing to death but n  inoma with  28a. Date of Injury (Month, Day You  28e. Place of Injury building, etc. (sician: To the best of ner: On the basis of ex	Pétal déath 3 ne of death 5 ne of death 6 ne	nderlying cause giver e Treatment 3 DOA Other (Specify) 28c. Injuny Work M 1 DOA Other (Specify) Treet, factory, office the occurred at the time vestigation, in my of the specific process.	26. Place of Dea	24a. Was an autopsystem  24a. Was an autopsystem  24b. Check only one  5 Resider  28d. Describe how  28f. Location (Str. City or Town,  and due to the carred at the time, da	Month  acco use contribute to s 2 □ No 3 □ Pro  24b. Were aut prior to or death? □ No □ 13 □ Ves  b)  acc 6 □ Other (Spec winjury occurred)  acet and Number or Ruisstate)  use(s) and manner as te and place, and due	the cause of death?  the cause of death?  bably 4 Aunknown  opsy findings available ompletion of cause of 2 No  all Route Number,  stated.  to the cause(s)

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 3. Time of Death 3:06 P 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2005 April 7, **Physician** Rosemary Elizabeth Tuinman /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City Town or Location of Death **Examiner** Silver Spring Montgomery Holy Cross Hospital If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 □ M 2 □ X F 77 Yrs. Director 216-22-3491 December 12, 1927 Maryland Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10a State 10h Counts 10d. Inside City Limits 7 is marked other than "natural", or Items 23a or 28a-f show treumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2XXNo Director Saint Mary's Leonardtown Maryland 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code USA 22555 Washington Street 20650 death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. Pages 1 and 2 should be filed within 72 hours after of health and Mental Hygiene. on the fitten 27 is marked other than "natural", or tles any or other traumatte event, the Medical Examinatary or other traumatte event, the Medical Examinatary. 1 ☐ Yes 2 📉 No If Yes, Give 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify þ Specify: White 3 Widowed 4 Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 U.S. Government Contract Supervisor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Charles Reindert Tuinman Agnes Gertrude Clements 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4610 Lawrence Street, Alexandria, Virginia 22309 Leo Reinhard Tuniman / Brother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State April permit. Page Department of Importent: If any injury or once. ' 4 ☐ Donation 5 ☐ Other (Specify) St. Aloysius Cemetery 12, 2005 Leonardtown, Maryland 22. Name and Address of Facility 21. Signature of Fun a Service Lic see Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, Maryland 20650 sman 23a. Part : Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician a Metastatic Ovarian Cancer 14 Months /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of: Examiner The law requires that the death certificate be executed the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical use as i IF FEMALE: 23c. ff yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy ó in the past 12 months? 1 ☐ Yes 2 X No Month Year Day 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 Pa 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed 1 ☐ Yes 2 ☐ No 2 X No To the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA dire 2 1 ☐ Yes 2 🗓 No after death.

I Director: After this d in by the funeral d 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 X Natural М 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide within 24 hours a To the Funerel I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical 29d. Date signed (Month. Dav. Year) 29c. License number 29b. Signature and tale of certifier one D33224 April 8, 2005 30. Name and address of person who completed cause of death (ftem 23a) (Type, Print) Ram Trehan, M.D. 50W Edmonston Drive, #303, Rockville, Maryland 20852 31. Date filed (Month, Day, Year) 32 Registrar's Signature .... State APR 1 1 2005 Registrar

			For Stata	State	of Marylai		artment of F				M M 1	n, gove	
			Registrar  1. Decedent's Name (First, Middl	e, Last)		00	runcate or i	Dealii		Date of Deatl	g. No.	15	3. Time of Death
	Physicia		Ma	ry Dove V	erdi/					Month April	Day 11, 200	Year )5	5:34 aM
	/Medic Examin		4a. Facility Name (If not institution				4b. City, Town, o	r Location o		1	4c. County o		<u> </u>
П			Harford	Memorial	Hospita	1	Havr	e de	Grace			Har	ford
	Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 ☑ F	7. Age (In yrs		If Under 1 Year Months Days	If Under	Min.	Date of Birth (Month, Day,	rear)	Cou	place (State or Foreign ntry)
	Director		235-34-2778	10 m 21/2 r	84	Yrs.			J	une 3,	1920	West	Virginia
	land ow		Usual Residence of Decedent  10a. State 10b. County		10c. C	ity, Town or L	ocation						10d. Inside City Limits
	Mary -f sh	to	Maryland Ha	rford			Havi	re de	Grace				1⊠Yes 2 No
	r 28a	lrec	10e. Street and Number				10f. Zip Code			10	g. Citizen of WI	hat Cou	ntry?
	23a c	aiD	100 Revolution	Street,	Apt. No	. 106	2	21078			τ	J.S.	Α.
	tams tams	by Funeral Director	11. Marital Status	12. Was Dec Armed F	cedent Ever in l orces?	J.S. 13.	Was Decedent of H	lispanic Ori	igin? (Specif n, Puerto Ric	y Yes or No- an, etc.)		- Ameri	can Indian, etc.
36	s afte	y F	1 ☐ Never Married 2 ☑ Mar. 3 ☐ Widowed 4 ☐ Divorced	If Yes, G	2⊠No iive		1 □ Yes 2 ☑ No	Specify:			Specify:		White
21215-0036	filed within 72 hours after deeth with the Maryland Hygiene. yther than "natural", or Itams 23e or 28e-f show ant, the Medical Examinat must be notified at	edt		t's Education	Dates.	16a. Dece	dent's Usual Occup	ation			16b. Kind of Bus	iness/In	
715	nin 72 n "ne Medik	plet	(Specify only highe Elementary/Secondary (0-12)	st grade completed	) (1-4or 5+)	(Give	kind of work done DO NOT use retired	during most	t of working				
212	d with	Completed	Eleven Years	College	(19401 34)		Homema	ker			Perso	nal	Residence
g	at Hy d oth	Be (	17. Father's Name (First, Middle,	Last)				18. Mothe	er's Name (F	irst, Middle, M	faiden Sumame	)	
Maryland	s 1 and 2 should be filed within 72 hours after deeth with the Marylan if Health and Mental Hygiene. Item 27 is marked other than "natural", or Itams 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at	2		ce Evans						Alta			
Nar	12 sh h and 7 is m traum		19a. Informant's Name/Relations Michael John Ve		hand)		ng Address (Street						
	1 and Health em 27 ther tr		20a. Method of Disposition	star (nas			osition (Name of matory or other place		ADL. I		e de Grace 20c. Location - C		aryland 21078
nor	ages ant of t: If it		1 ☐ Burial 2 ☑ Cremation  4 ☐ Donation 5 ☐ Other (S		1 State		matory or other places s & Co., In		04/14			-	Pennsylvania
Baltimore,	permit. Pages 1 an Department of Heal Important: If Item 2 any Injury or other		21. Signature of Funeral Service		1100	2	Name and Addre	es of Facilit	hv				
ñ	Depare Impo		Monera. Ne	. HTOURS	OM S		Lee A. Par Perryvill					me,	P.A.
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that	caused the dea								Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	1	MYOC	ARDI	AL I	DNF	ARC	TIOM	J.		Onset and Death
	/Medical Examiner		resulting in death)	Due to	(or as a conse	quence of):							
	LXUIIIIICI	L	Sequentially list conditions,	b. Due to	o (or as a conse	quence of):							
	pet lisit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		(OI as a COIISO	querice or).							
Ć	execu n and ial-tra	Examiner	that initiated events resulting in death) Last	C. Due to	(or as a conse	quence of):							
8760,	icate be executed physician and s the burial-transit	dical		d									
9	ng ph	Medi	IF FEMALE:	T.							1	1	
Вох	death certific e attending p id for use as	lan/I	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live	utcome of pregr birth 2 - Fet	al death 3[	Ectopic pregnancy	/			23d. Date Mont		ery Day Year
0	that the death ed by the atte detached for	Physician/Med	1 ☐ Yes 2 XNo 9 ☐ Unknown	4□Preg 9□Unki	nant at time of	death 5[	Other (specify)						ou, rou
<u>α</u>	that the ed by detac	Ph	Part II. Other significant conditi	ons contributing to	death but not re	sulting in the u	inderlying cause giv	en in Part I.		23e. Did tob	acco use contrib	oute to t	he cause of death?
ds,	The law requires that the the bas been signed by the bage 2 should be detached.	2								1 ☐ Ye	s 2 No 3	B 🗌 Prot	pably 4 Unknown
Vital Record	w requires been s' should	Completed								24a. Was ar	1 24b. W	ere auto	opsy findings available
Be	The lay te has age 2	ome								autopsy perform 1 Tes 2	ved? de	ath?	mpletion of cause of 2□ No
ta		BeC	25. Was case referred to medica examiner?	1				26. Place	of Death (C	heck only one			22.10
	hysic his ce I dire	To	1 ☐ Yes 2 XNo	Hospital: 1	Inpatient 2	ER/Outpatie		4 LINU	ırsing Home	5 🗌 Reside	nce 6 Other	(Specif	(y)
ח	ding Physician: The I h. After this certificate he funeral director, page	on:	27. Manner of Death 1 Natural 5 ☐ Pendir	'9	of Injury oth, Day Year)	28b. Time o Injury	Wor			I. Describe ho	w injury occurre	d	
Division of	or Attending after death. Director: After in by the funer	icat	2 Accident investi	not be	e of Injury - At I	omo farm et	M 1 []	Yes 2 🗆		Location /Str	eat and Number	ror Rue	al Route Number.
<u>&gt;</u>	after Direction by	ertification;	4 ☐ Homicide determ	build	ding, etc. (Spec	ify)	reet, factory, office		201	City or Town,		or riaic	arriode realibor,
	Hospital 24 hours a Funeral I	aic	29a. Certifier 1 Certifyin	ng Physician: To th	ne best of my kn	owledge, deal	h occurred at the tin	ne, date an	id place, and	due to the ca	use(s) and man	ner as s	tated.
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	edicai	(Check only 2 Medical one)	Examiner: On the and ma	basis of examin nner stated.	ation and/or ir	vestigation, in my o	pinion, deal	th occurred	at the time, da	ite and place, ar	nd due to	o the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifie	1/1 12	7		29c. Licens	e number	~ I	29	d. Date signed		
			1 100	1	<u>v</u> ,	MD	, _	217	05/		1711/1		1,2005.
	3		30. Name and address of person	who completed cau	se of death (Ite	m 23a) (Type,	RAD. H	ARF	ORD	MEN	IORIAL	H	SPITAL 4d.21078
	Sta	te.	31. Date filed (Month, Day, Year,				7110)	-  -	THUK	F DE	COVACE		40.21078
	Registr		APR 1 1 2005	Blem	Registrar's Sign	porte							

Registrar DHMH 17 Rev 1/2001

VERDI, MARY D

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Ragistrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death **Physician** Day Year 04/02/2005 Mary L. Van Horn A M 4:40 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Hospice of the Chesapeake Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth Month Day Year) 03/05/1913 **Funeral**  Birthplace (State or Foreign Country) 1 ☐ M 2 🗓 F 92 Director 220-05-1646 Virginia Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location item 27 is marked other than "natural", or itema 23a or 28e-f show other traumstic event, the Nedical Examinat must be notified at 10d. Inside City Limits Director TX Yes 2 □ No Maryland | Anne Arundel Annapolis 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 2521 Tudo Court 21401 USA death by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2X No Specify: 3 ☑ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 7 Hygiene. other than "r Elementary/Secondary (0-12) College (1-4or 5+) . Pages 1 and 2 should be filed wi tment of Health and Mental Hygien tant: if item 27 is marked other th jury or othar traumatic event, the 12 Suburban Trust Employee Banking 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Grover H. Palmer 2 Lollie B. Bowie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Steven Van Horn/ Grandson 1310 Prince Street Alexandria, VA 22314 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cometery, crematory or other p. Fort Lincoln Cemetery 1 ☐ Purial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: if any injury or once. \* 4 ☐ Donation 5 ☐ Other (Specify) 04/06/2005 Brentwood, MD 21. Signature of Funeral Service Lie 22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Road Bowie, MD 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner te Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): The law requires that the death certificate be executed the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Box 68760 Physician/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) P.0. the 9□ Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ pe 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 反Unknown Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No cate has to autopsy performed? 2 X10 1 Yes fo the Hospital or Attending Physician: director 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence NOther (Specify) Hospice ဥ 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of eath 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Natural 2 Accident 5 Pending death. investigation 1 ☐ Yes 2 ☐ No Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) To the Funeral Direct 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature nd title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D57028 4-4-05

State Registrar HOPRA M.D. 1000 Ridgely Ave. St. 231 Annapolis, M.D. 2140

me and address of person who completed cause of death (Item 23a) (Type, Print)

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Year **Physician** 2139 RUTH VARANO /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner SILVER SPRING HOLY CROSS HOSPITYPL 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) July 4, 19 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1□ M 2 F 215-50-9945 56 Yrs. Virginia Director Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits in then "naturel", or Iteme 23a or 28e-f show the Medical Examiner must be notified at 1 ☐ Yes 2 X X X o Director Maryland Montgomery Kensington 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 10710 Bentley Lane 20895 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status e filed within 72 hours after al Hygiene. 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: δ 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Horticulturist Horticulture 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other treumatic event ones. 17. Father's Name (First, Middle, Last) Gaines Oliver Loyd Ruth Ella Thompson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Gary R. Varano/ Husband 10710 Bentley Lane, Kensington, MD 20895 Date 5, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State April 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metropolitan Crematory 2005 \* 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, Virginia 21. Signature Jungral Service Licensee 22 Name and Address Pifacility Funeral Home Inc Merz 500 University Blvd, W, Silver Spring, Md 20901 23a. Part1. Effer the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ANTENIOSCIEMENTE CHAROIEUNSCULAR DISENSE Pnysician /Medical Due to (or as a consequence of): Examiner ASPIRATION AS TERLMINAL ELBA Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) attending physician and for use as the burial-transit requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year Day 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown is been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ , It MATATERSIN 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? (es 2 No certificate has page 2 1 ☐ Yes After this certifical funeral director, p the Hospital or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 XYes 2 □ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 24 hours after death. 2 Accident 6 Could not be determined 3 🗀 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Adedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check anh one) within 24 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) (OME April 4, 2005 015236 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CARL I WARCON, MO 11125 ROCKNUS PINE, KERVIUE, MO 10852 . Registrar's Signature 31. Date filed (Month, Day, Year) State 06 Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** 2005 08.03 AM Edith Mae Williams /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Upper Chesapeake Medical Center Cecil Bel Air If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🕱 F Days Hours Min. Yrs. Director Delaware 222-22-2468 68 Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b County 10d. Inside City Limits 28a-1 ahov other traumatic evant, the Modical Exprinterrust by notified at 1 Nes 2 No Directo Delaware Sussex Greenwood 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 19950 7-B Greenwood Acres USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Never Married 2 ☐ Married ō 1 ☐ Yes 2 No Specify: 3 Widowed 4 □ Divorced \*natural\* Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) d 2 should be filed within 7 h and Menfal Hygiene. 7 is marked other than \*r Elementary/Secondary (0-12) College (1-4or 5+) CNA Health Care 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be s 1 and 2 should by Health and Menfitsm 27 is marked Mifflin Catherine 2 James Short 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1572 Harford Sq. Dr., Edgewood, Maryland 21040 Eugene Short / Son permit. Pages 1 and Department of Healt Important: if itam 2' any injury or other i 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Zion Church Cem. 04-09-2005 4 ☐ Donation 5 ☐ Other (Specify) Georgetown, Delaware 21. Signatura of Funeral Service Liber 23a. Party, Enter the Isease, or com shock, or heart failure. List only 22. Name and Address of Facility Bennie Smith Funeral Home 274 Rehoboth Blvd., Milford, Delawa<u>re 19963</u> or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ist only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician one week disease or condition resulting in death) /Medical Due to (or sag nsequence of) Examiner Sequentially list conditions, I any, leaving to in rediate cause. Enter Underlying Cause (Disease or injury Examine mon Hos no m that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: . If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 Yes 250 No 9 Unknown Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐No 3 ☐ Probably 4 ☐ Unknown Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No certificate has autopsy 2A No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification; To 2 ER/Outpatient 3 DOA this 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred 1 Natural 5 Pending Accident investigation 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

sion of Vital Records, within 24 hours after deaf

> State Registrar

Medical

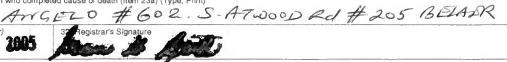
31. Date filed (Month, Day, Year)

APR 0 6 3605

29a. Certifier

(Check only one)

29b. Signature and title of certifier



MO

and manner stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

D0056607

29d. Date signed (Month, Day, Year)

05-02260 NICK W WILLEY WHM

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.    1			ľ	1 - For State Registrar	State of M		epartment Certificate				jiene leg. No.	005	13662
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Physician (Medical Examiner    Saminer   Samin				23a. Part1. Enter the disease, or co	mplications that causely one cause on each	d the death. Do n	ot enter the mode	of dying, such	h as cardiac	St Mi or respiratory are	chae	els, Mo	Approximate 63
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FEMALE: 230. Was decedent pregnant in the past 12 months?   1   Ves 2   No   2   Nother with past 12 months?   1   Ves 2   No   3   Probably 4   Unknown   24a. Was an very part of the past 12 months?   1   Ves 2   No   3   Probably 4   Unknown   24a. Was an very part of the past 12 months?   1   Ves 2   No   3   Probably 4   Unknown   24a. Was an very part of the past 12 months?   1   Ves 2   No   3   Probably 4   Unknown   24a. Was an very part of the past 12 months?   1   Ves 2   No   3   Probably 4   Unknown   24a. Was an very part of the past 12 months?   1   Ves 2   No   3   Probably 4   Unknown   24a. Was an very part of the past 12 months?   1   Ves 2   No   3   Probably 4   Unknown   24a. Was an very part of the past 12 months?   1   Ves 2   No   3   Probably 4   Unknown   24a. Was an very part of the past 12 months?   1   Ves 2   No   3   Probably 4   Unknown   24a. Was an very part of the past 12 months?   1   Ves 2   No   2   No   3   Probably 4   Unknown   24a. Was an very part of the past 12 months?   1   Ves 2   No		led sit	nine	cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence o	11):						
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FFEMALE: 23b. Was decedent pregnant in the past 12 months?   23c. If yes, outcome of pregnancy   1   1   1   2   1   1   2   2   2   2	09/	e be e	Sai		d								
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State   Stat	ŏ	th cer tendir r use	an/N	23b. Was decedent pregnant			3 □Ectopic pre	onancy			23		
25. Was case referred to medical examiner?    Comparison    E	e dea the at ned fo	sici	1 ☐ Yes 2 ☐ No	4 ☐ Pregnant a							Month	Day Year	
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2 (Accident 3   Suicide 4   Homicide   State	0	ig Ph ter thi	T:uc		28a. Date of Inju	ury 28b. T	ime of 28			28d. Describe h	ow injury	occurred	1
29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier  29b. Signature and dudress of person who completed cause of death (Item 23a) (Type, Print)  29c. License number  OCME  29d. Date signed (Month, Day, Year)  MARCH 31, 2005  31. Date filed (Month, Day, Year)  State  31. Date filed (Month, Day, Year)  Day, Year)  111 Penn Street Baltimore, Maryland 21201	Š	endir sath. or: Af he fur	atic	2 Accident investigat	ion Found 3-30			1 🗆 Yes	2 No	subject d	YOWNED	s coma en	cold
29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier  29b. Signature and dudress of person who completed cause of death (Item 23a) (Type, Print)  29c. License number  OCME  29d. Date signed (Month, Day, Year)  MARCH 31, 2005  31. Date filed (Month, Day, Year)  State  31. Date filed (Month, Day, Year)  Day, Year)  111 Penn Street Baltimore, Maryland 21201	ž	or Att tlar de lirect n by t	rtifi	datamia	ad   200. Flace of III	tc. (Specify)		office		City or Tow	n, State) (	Number or Rura	A Route Number at a
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OCME  MARCH 31, 2005  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  LING LI, M.D. 111 Penn Street Baltimore, Maryland 21201  State  31. Date filed (Month, Day, Year)  32. egistrar's Signature		vithin o the	Mec		and mainers		29c.	License num	ber			-	
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				artment of Health and Mertificate of Death		ene 2005   13663
	Physici /Medi		1. Decedent's Name (First, Middle, Last) Florence Kaye Yates		2. Date of Death Month April 3	Day Year 2005 1:42 A <sup>M</sup>
	Examir		4a. Facility Name (If not institution, give street and number)  1469 Nieman Road	4b. City, Town, or Location of Death Shady Side		4c. County of Death Anne Arundel
ľ	Funeral Director		5. Social Security Number  577-07-0797  Usual Residence of Decedent  6. Sex 1	If Under 1 Year   If Under 24 Hrs.   Months   Days   Hours   Min.	8. Date of Birth (Month, Day, Y) Dec 5, 1	ear) 9. Birthplace (State or Foreign Country) 1919 Washington, DC
	Maryland a-f show	ctor	10a. State 10b. County 10c. City, Town or L MD Anne Arundel Shady			10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	th with the 23a or 28	Funeral Director	10e. Street and Number 1469 Nieman Road	10f. Zip Code <b>20764</b>	10g	. Citizen of What Country? USA
900	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 800ce.	by	11. Marital Status  1 Never Married 2 Married  12. Was Decedent Ever in U.S.  Armed Forces?  1 Never Married 2 Married  1 Never M	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2X No Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
21215-0036	d within 72 h giene. er than "natu , the Wedical	Completed	(Specify only highest grade completed) (Give	ident's Usual Occupation Is kind of work done during most of worki DO NOT use retired)  Urch Secretary	ng 16i	b. Kind of Business/Industry  Church
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	s 1 and 2 shot Health and item 27 is nother traun		Ralph Yates (son) 1469		y Side, M	
Baltimore,	Pages 1 ment of h ant: If ite		'4 Donation 5 Other (Specify) Lakemont	Mem. Grdns. Apri.	5 Da	c. Location - City or Town, State  Vidsonville, MD
Balt	permit. Depart Import any inj		21. Signature of Funeral Service Licensee 2.	2. Name and Address of Facility Lee 125 Southern Maryla	Funeral and Blvd.	Home Calvert, PA Owings, MD 20736
0. 11. 0	Physician /Medical	į	Page Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause or each line.  Immediate Cause (Final disease or condition resulting in death)	ter the mode of dying, such as cardiac o	r respiratory arrest,	Approximate Interval Between Onset and Death
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. 109/	ate be executed hysician and the burial-transit	cal Examiner	ff any, leading to immediate cause. Enter Inderlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  C. Due to (or as a consequence of):			
.O. Box 68	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be delached for use as the burial-transit	Physiclan/Medical		□Ectopic pregnancy □ Other (specify)	**	23d. Date of delivery Month Day Year
rds, P	w requires that been signed b should be deta	þ	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.	23e. Did tobaco	co use contribute to the cause of death?  2 No 3 Probably 4 Unknown
ital Records,		Completed			24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
Division of Vit	ding Phys h. After this funeral di	atlon: To Be	25. Was case referred to medical examiner?  1		V	e 6 □Other (Specify) njury occurred
DIVIS	P affe	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)		City or Town, St	
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical	29a. Certifier  (Check only one)  Certifying Physician: To the best of my knowledge, deatt of the death of th	vestigation, in my opinion, death occurre	nd due to the cause d at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
}	To Cor		29b. Signature and title of certifier	29c. License number	<sup>29d.</sup>	Date signed (Month, Day, Year)
	5		30. Name and address of person who completed cause of death (Item 23a) (Type,	Printy Avenue	Anne	10 21401 ilo
	Sta Registr	_	31. Date filed (Month, Day, Year)  APR 0 5 2005	Spelle		

			For Stete Registrer		State o	of Maryla	•	artmer <i>rtificat</i>				ental Hyg	giene	nc	10001
	Physici	an	1. Decedent's Name (Firs		•		,					2. Date of Dea Month		Year	3. Time of Death
	/Medic	al	DIETER ( 4a. Facility Name (If not in			mber)		4h City	Town o	Location	of Oeath	APRIL	4c Count	2005 y of Death	5:50AM M
	Examin	ier	WILLIAM					i.e. ony,		STON	or ood			TALBO	Т
	Funeral		5. Social Security Number		Sex MXDM 2□F		s. last birthday)	If Unde Months	r 1 Year Days		24 Hrs. Min.	8. Cate of Birtl (Month, Day MAY 10	h		lace (State or Foreign try) MANY
	Director		365-36-6606 Usual Residence of Dece	)	20 141 2	75	Yrs.					MAY 10	1929	GER	MANY
	nyland how			County		10c. C	City, Town or Lo	ocation						1	0d. Inside City Limits
	ith the Marylan or 28a-f show te notified at	Director	MD	LAT	вот		EAS	TON							1 XYes 2 No
	with t		10e. Street and Number 501 DUTCHN	IANS T.	ANE			10f. Zip		.601			10g. Citizen of	What Cour	itry?
	after death with the Maryla or Itams 23a or 28a-f shor miter must be maiffed at	Funeral	11. Marital Status		12 Was Dec	edent Ever in	U.S. 13.	Was Dece			igin? (Spe	cify Yes or No- Rican, etc.)	14. Ra	ce - Americ	
36		by Fu	1 ☐ Never Married 2 3 ☐XWidowed 4 ☐ D		Armed For 1 Yes If Yes, Gir Year or D	2 ☐XNo ve	1	1 ☐ Yes				nican, etc.)	Speci	ick, White,	etc.
Ö	"natural",			ecedent's E		Dates:	16a. Dece	dent's Usu	al Occup	ation			16b. Kind of E	WHI'	
215	thin 72 e. en "na	Completed	(Specify only Elementary/Secondary		ade completed) College (	1-4or 5+)	(Give	kind of wo DO NOT u	rk done i	durina mos	st of worki	ng			,
12	be filed within tal Hygiene. od other than event, the M.		12		4		co	NSULI	TUA	10.11.11		<b>75</b>		NEERL	NG
Maryland 21215-0036	e da ia b y	o Be	17. Father's Name (First, KARL ZERRE		)							(First, Middle, CLAUSS	Maiden Suma	me)	
aryl	s 1 and 2 should f Health and Men item 27 is marke other traumatic	2	19a. Informant's Name/R		Type, Print)		19b. Maili	ng Address	(Street			I Route Numbe	r, City or Town	, State, Zip	Code)
	5 5 5 E		W. THOMAS		AIN/PER					WASHI		N ST. E	ASTON.	MD 2	L601
Baltimore,	<u> </u>		20a. Method of Disposition 1 Burial 2 ☐ Crer	nation 3		State	Place of Dispo cemetery, crea	matory or o	other plac			ate	20c. Location	- City or To	wn, State
謹	1 5 th 12		`4 □Donation 5 □ 0 21. Signature of Funeral 9			S	r. PAUL	'S CE 2. Name ar			to all the second secon	2005	CORDO	VA, M	RYLAND
ä	permit. Depart Import any nj		TIONN	-	MER	RERA		FELLO	WS,	HELFI	ENBEI	N & NEW	NAM FU	NERAL	HOME PA
			23a. Part1. Enter the dise shock, or heart failu	ase, or com	plications that	caused the dea	ath. Oo not ent	ter the mod	le of dyin	g, such as	cardiac o	r respiratory ari	est,	21001	Approximate Interval Between
	Priysician		Immediate Cause (Final disease or condition resulting in death)	024	a	10	220	~	-	2/00	_				Ogset and Death
	/Medical Examiner		resulting in dealth)	(	Oue to	(or as a conse	equence of):		14	in	1				1000
		Jer	Sequentially list condition cause. Enter Underlying Cause (Disease or injury	s,	b. — Due to	(or as a cons-	quenda de	210			11	. 1	)		7
	be executed sician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	1	c	س	(il	WE	12	rice	CON		15-LE	12	1/2ur1
1,6) 8760,	death certificate be executed e attending physician and id for use as the burial-transi	ical Ex	Tooling III doddin 2201		. Due to	(or as a conse	iquence of);								/
(A) 687	uficate g phys as the	ledic			_ d										
30x 33	eath certific attending pl	Physician/Medi	IF FEMALE: 23b. Was decedent pregrin the past 12 month		23c. If yes, ou 1⊟Live b	tcome of pregr		∃Ectopic pi	regnancy					ate of delive	•
, 0.	he dea the at ched fo	ysici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	S.f	4⊟Pregr 9⊟Unkn	nant at time of own		Other (sp					M	onth	Day Year
SOS Vital Records, P.O	res that the de igned by the a be detached	by Ph	Part II. Other significant of	conditions	contributing to d	eath but not re	sulting in the u	nderlying o	ause give	en in Part I		23e. Did to	bacco use con	fibute to th	e cause of death?
Sp	w requires been sign should be											1 □ Y	es 2 No	3 ☐ Prob	ably 4 Unknown
900	law re las be	Completed								_		24a. Was a	an 24b.	Were autor	osy findings available npletion of cause of
a a	sician: The law s certificate has b lirector, page 2 s											perfor 1 ☐ Yes	med? 20 No	death? 1 ☐ Yes	2 □ No
Vit Vit	siciar s certif lirector	o Be	25. Was case referred to— examiner? 1 ☐ Yes 2 No	medical	Hospital:	Inpatient 2[	☐ ER/Outpatier	nt 3 🗆 DC	Othe	ar 2	of Death	(Check only or		(0	
of of	ding Physician: The In. After this certificate hat funeral director, page	$\vdash$	27. Manner of Death	Desides		of Injury th, Day Year)	28b. Time or		28c. Injury Work		ALL WATER TO	8d. Oescribe h	ence 6 ⊟Oti ow injury occui	_ ` ' '	)
sior	Attendir death. ctor: Af y the fur	catic	2 Accident	Pending investigation Could not b	n			М	1 🗆 '	Yes 2□					
Division	l or Atten after deat Director: in by the	ertification;	4 ☐ Homicide	determined	200. Place	of Injury - At I ing, etc. <i>(Spec</i>	home, farm, str iify)	eet, factor	y, office		2	8f. Location (S City or Tow	treet and Numi n, State)	ber or Rura	Route Number,
	To the Hospital or Attending Physician: The law requires that the within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached.	O	29a. Certifier 1	ertifying Ph	nysicien: To the	best of my kn	nowledge, deatl	h occurred	at the tin	ıe, date an	nd place, a	ind due to the c	ause(s) and m	anner as st	ated.
	To the Howithin 24   To the Fuccompletely	ledical	one)		niner: On the b	asis of examin ner stated.	ation and/or in				ith occurre	ed at the time, d	ate and place,	and due to	the cause(s)
	with To	Σ	29b. Signature and title of	gertifier	P	w	D			number 7	5-11	2	9d. Date signe		
	101		30. Name and address of	person who	completed caus	se of death /Ite	m 23a) (Type			, ,	00		4-4-	0)	
	10)		ROBERT B.			· ·	DLEWILI		EA	STON	MD '	21601			
	Sta Registr	_	31. Date filed (Math	Vaarl		Yegistrar's Sign	nature				- 111	-1001			
	ricgisti	या		-		A STATE OF THE STA	400	and.							

Leroy Artis 05-2673 AKJG

State of Maryland / Department of Health ar 1- State Amend Item 1&Unpend Item 23a, pter life 23te per Deat G8	nd Mental Hygie	ene <sup>UUU</sup>	1366
Decedent's Name (First, Middle, Last)	2. Date of Death	Day Year	3. Time of De

J.G		1	State AMENG ITEM IC Registrar	Sunpena Ite	m zsa, pe	Hificate of	Death 04	2 2-12-0	Reg. N	1S lo	
Phys	sician		1. Decedent's Name (First, Middle, La			_		2. Date of D Month		ay Year	3. Time of Death
	edical	ļ			y Artis, l			April	16,	2005	11:21 A.M
Exa	miner	4	la. Facility Name (If not institution, giv		1		or Location of De	eath		c. County of Deat	
			Prince George's		•		erly	tre la Data at D		Prince G	
Fune		1	5. Social Security Number 6. S	iex /. Age ☑M 2□F	(In yrs. last birthday Yrs.	Months Days		in. (Month, D			nplace (State or Foreigr untry)
Direct	or	-	578-80-5771 Usual Residence of Decedent		47			Nov 7	, 195	07	D.C.
_ ≤ ≥		-	10a. State 10b. County		10c. City, Town or L	ocation		<del></del>			10d. Inside City Limits
Mary -f sh	Į	5	Md. Prince	George			Largo				1X Yes 2 □ No
th the Marylar or 28a-f show	Director	2 -	10e. Street and Number			10f. Zip Code			10g. 0	Citizen of What Co	untry?
th with		2	904 Narrow Leaf Drive				20774			U.S.	A.
re, Maryland 21215-0036 s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hyglene. tiem 27 is marked other than "neturel", or Hems 23e or 28e-1 show other traumatic event. The Maddical Energing must be netiting at	Funerai		11. Marital Status	12. Was Decedent Ev Armed Forces?	ver in U.S. 13	. Was Decedent of If Yes, specify Cul	Hispanic Origin?	(Specify Yes or N	0-	14. Race - Ame	
6 after or the	l i	3	1 ☐ Never Married 2 ☑ Married	1 ☐ Yes 2 ☑ No		1 Tes, specify Cui		eno moan, etc.)		Black, White	
ours ref.	à	2	3 Widowed 4 Divorced	Year or Dates:		TLITES ZODING	зр <del>о</del> спу.			Specify:	Black
15-0036 72 hours after dea "neturel", or items	Completed		15. Decedent's E- (Specify only highest gra	ducation ade completed)	16a. Dec	edent's Usual Occu e <i>kind of work done</i> DO NOT use retin	ipation a during most of	working	16b.	Kind of Business/	Industry
12 sign	9	-	Elementary/Secondary (0-12)	College (1-4or 5+	) life.					U. S. Post	al Service
Nagar t	ن	5	12			IVIA	il Carrier	(5)	1		
be fi	9	ă	17. Father's Name (First, Middle, Last,				18. Mothers I	Name (First, Middle	<sub>в, маю</sub>		
faryland 2121 2 should be filed within and Mental Hygiene. Is marked other than aumatic event, the Maraumatic	P	2		Artis Sr	101 11		121				
Baltimore, Maryland 21215-0036 permit. Pages I and 2 should be filed within 72 hours att Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "neture!", or my fullury or other traumatic event, the Modical Event.	- 12		19a. Informant's Name/Relationship (	туре, Рппт)		ling Address (Stree			-	or lown, State, 2	up Code)
e, e		-	Deanna Artis  20a. Method of Disposition		20b. Place of Disp		al Dilve La	Date	,	Location - City or	Town State
Iges If it		1	1 ☑ Burial 2 ☐ Cremation 3 ☐		cemetery, cri	ematory or other pla	1		200.	_	
ti Partiment		-	`4 □Donation 5 □ Other (Specif	-		Lincoln Cem		04/22/05		Brentwoo	ou, iviu.
Baltimore, Ma permit. Pages 1 and 2.3 Department of Health at Importent: If item 27 Is	ouce		21. Signature of Funeral Service Licer	1500	1	22. Name and Addr Fstep F	-	neral Service			
		+	22a Part 1 Enter the disease or com	plications that caused t	bo double. Do not or	1600 F	utaw Place	Raltimore M	d 212	217	Approximate
			23a. Part1. Enter the disease, or comshock, or heart failure. List only	one cause on each line		itel the mode of dy	ing, such as care	ado or respiratory	arrest,		Interval Between Onset and Death
Pnysicia /Medic	_		Immediate Cause (Final disease or condition resulting in death)	Cardiome							
Examin	_	1		Due to (or as a	consequence of):						
	<b>1</b>		Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	consequence of):						
ted nsit	-		Cause, Enter Underlying								
xecu al-tra	Examiner	7	that initiated events resulting in death) Last	cDue to (or as a	consequence of):						
ox 68760, certificate be executed oding physician and	160		(	d							
687 ficate	/Medical			. d							
Centi			IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of		-				23d. Date of deli	very
death death	2	2	in the past 12 months? 1 ☐ Yes 2 ☐ No	1□Live birth 2 4□Pregnant at ti		□Ectopic pregnand □ Other (specify)	cy 			Month	Day Year
P.O. hat the od by the detached	SAC	2	9 Unknown	9□ Unknown							
Vision of Vital Records, P.O. Bot Attending Physician: The law requires that the death codesth.  ector: After this certificate has been signed by the atten extension of the innead director, page 2 should be detached for a	Completed by Physician		Part II. Other significant conditions of	contributing to death but	not resulting in the	underlying cause g	iven in Part I.	23e. Did	tobacco	use contribute to	the cause of death?
rds quire on sig	Pa	2	Narcotism					1 🗆	Yes	2∐No 3∏Pro	obably 4 Unknown
aw re	jet							24a. Wa		24b. Were au	topsy findings available completion of cause of
Re line lie ha	,	5						perl	opsy formed? 2 \(\sigma\) 1	death?	2 No
an:	BeC		25. Was case referred to medical				26. Place of I	Death (Check only		40 -2.00	20,110
yslci yslci is cer	ToB	ב כ	examiner? 1 XYes 2 ☐ No	Hospital:	t 2 XER/Outpatie	ent 3 DOA	ther: 4 Nursin	g Home 5 ☐ Res	sidence	6 □Other (Spec	cify)
g Ph g Ph ler th			27. Manner of Death	28a. Date of Injury (Month, Day	Year) 28b. Time	of 28c. Inju		28d. Describe			
isior Witendin death. ctor: Aff	atio		1 ☑Natural 5 ☑ Pending 2 ☐ Accident investigatio	n	, oar, mary		Yes 2 No				
Division of Vital Records, or Attending Physician: The law requires taffer death.  Director: After this certificate has been signed in by the funeral director, page 2 should be of			3 Suicide 6 Could not b	28e. Place of Injur building, etc.	y - At home, farm, s	treet, factory, office		28f. Location City or To	(Street	and Number or Ru	ral Route Number,
Dite our rs after el Dite	Certification:	בו כ		31 010.	1			1			
Division of Vital Records, P.O. B. To the Hospitel or Attending Physician: The law requires that the dealt within 24 hours after death. To the Funeral Director, After this certificate has been signed by the atterprenisty lifled in by the funeral director, page 2 should be detached for	163	2	29a. Certifier 1 Certifying Pt (Check only 2 Medicel Exer	nysicien: To the best of miner: On the basis of e	my knowledge, dea	th occurred at the to	time, date and pla	ace, and due to the	cause	(s) and manner as	stated.
the Hin 24 the F	Medical	ב	one)	and manner state	ed.						
	1	=	29b. Signature and title of certifier	1 1		29c. Licer	nse number			ate signed (Month	
peric	)	1	> rummes	melfrell	- MO	OCIVII	<u> </u>		Ap	ril 17, 2	2005
+ to	10		30. Name and address of person who	A	ath (Item 23a) (Type		Penn St	root De	1 +	3.5	-1 1 01001
/			MARYSRAM	17 KODEN	1.0:	111	TEITH DC	reet ba.	TLTI	ore, Mar	yland 21201
<b>%</b> .	State	3	31. Date filed (Month, Day, Year)	2. 2005	's Signature	Board	•				

amend	item/26, per Maryland / Department of H	Ensure All Copies Are Legible.
Fa.,	State of Maryland / Department of H	lealth and Mental Hygiene

	KJ		1- State Unpend Item	State of M	aryland	/ Dep	artment of H	ealth and M	ental Hy	giene	
			Registrar Perior I Lem     Decedent's Name (First, Middle, I		i i pe	166	removate of t	yearr <sup>15</sup>	2. Date of De	Reg. No. 4 U	3551
	Physic		Bobbie Jo Allen						Month	Day Ye	3. Time of Death
	/Medi Examii		4a. Facility Name (If not institution, g	ive street and number)			4b. City, Town, or	Location of Death	April	18, 2005 4c. County of E	09:23 p.
			102 S. Kelly Aver	nue, Apartm	ent 9		Bel Ai	r		Hari	ford
d	Funeral Director			Sex 7. Ag	e (In yrs. las	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da		Birthplace (State or Foreign Country)
5			220-84-1777 Usual Residence of Decedent						09/29	/1971 Ge	rmany
	arylan show	_	10a. State 10b. County		10c. City, 1	Town or Lo	ocation				10d. Inside City Limits
	with the Maryland a or 28a-f show	Director	MD Harford	đ	Jopp	a					1 □ Yes 20 No
	th with						10f. Zip Code			10g. Citizen of Wha	100
	ter death Items 23	Funerai	408 Hardin Drive  11. Marital Status	12. Was Decedent	Ever in U.S.	13.	21085 Was Decedent of Hi	spanic Origin? (Spe	cify Yes or No	United St	ates American Indian,
98	or Ite	/Fur	1 Never Married 2 Married	Armed Forces?  1  Yes 2 1	No		If Yes, specify Cuba 1 ☐ Yes 2 ☐ M6	n, Mexican, Puerto F Specify:	Rican, etc.)	Black, V	Vhite, etc.
000	72 hours "natural", edical Exe	d by	3 ☐ Widowed 4 ☑ Divorced	Year or Dates:						Specify: W]	nite
21215-0036	in 72 n "nat	Completed	15. Decedent's (Specify only highest g	rade completed)		(Give	dent's Usual Occupa kind of work done of DO NOT use retired	luring most of working	ng	16b. Kind of Busine Medical	ess/Industry
212	nit. Pages 1 and 2 should be filed within 7: ratment of Health and Mental Hygiene. ortent: If Item 27 is marked other then "n injury or other traumatic event, the Medicinius of the traumatic event, the Medicinius or other traumatic events.	omi	Elementary/Secondary (0-12)	College (1-4or 5			Health Ai			Medical	
nd	be filed tal Hygid d other svent, I	Bec	17. Father's Name (First, Middle, Las	st)				18. Mother's Name	(First, Middle,	Maiden Sumame)	
Maryland	ould to	To	Dale Hash					Peggy L.			
Mar	d 2 sho th and 7 is mu trauma		19a. Informant's Name/Relationship Peggy L. Doty /mo							er, City or Town, Stat	e, Zip Code)
	1 an Heali tem 2		20a. Method of Disposition	LHEE	20b. Plac	e of Dispo	Hardin Dr. esition (Name of	Da	, MD 21	20c. Location - City	or Town State
OE	Pages ent of nt: If II		1 ☐ Burial 2 ☐ Cremation 3  '4 ☐ Donation 5 ☐ Other (Spec		cem	etery, crer	natory or other place	A	pr 22		e, Maryland
Baltimore,	permit. Page Department of Importent: If any injury or once.		21. Signature of Funeral Service Lice		6986	22	ke Cremato 2. Name and Addres	s of Facility			e, Maryrand
<u>m</u>	Depril Impo		Huli	u	>	8	remation a 717 Green	Pastures D	rive E	Baltimore.	Maryland 2128
	Physician /Medical Examiner		23a. Part1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	y one cause on each iir	e Into	xicat	er the mode of dying				Approximate Interval Between Onset and Death
	po iii	iner	Sequentially list conditions, if any cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	a consacilian	(tr. sa					
	cate be executed physician and the burial-transit	Examiner	that initiated events resulting in death) Last	c Due to (or as	a consequen	ice of):					
38760,	cate be e. physician the buria	dicai E			a consequent	.00 01).					}
-		ledic		d							
O. Box	at the death certific by the attending p tached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☑ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal de	ath 3	Ectopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year
S, P	es that igned to be deta	by PI	Part II, Other significant conditions	contributing to death bu	ut not resultin	g in the ur	nderlying cause give	n in Part I.	23e. Did to	bacco use contribute	to the cause of death?
brd	w require been signated should t								1 🗆 Y	'es 2□No 3□	Probably 4 Dunknown
I Record	The la ate has page 2	Completed							24a. Was a autop perfor	sy prior to death	autopsy findings available to completion of cause of ?
Vital	Physicien: this certificated al director.	Be	25. Was case referred to medical examiner?	Hospital:			011	26. Place of Death		ne)	
of	Phys	1. 10	1 Xes 2 No 27. Manner of Death	1 Inpatie		Outpatien  b. Time of	t 3 DOA Other	- Wirth Sing Hom		ence $6X$ Other $(S_i$	pecify) At scene
Division	Attending or death.	Certification:	1 ☐ Natural 5 ☐ Pending investigated	Found th, Day 4-18-05		und <sup>y</sup> 22	P <sup>M</sup> 28c. Injury Work'		d. Describe n	ow injury occurred	unic
Οİ	9 # 15 E	ırtifi	3 Suicide 6 La Could not l 4 Homicide determined	28e. Place of Inju	iry - At home :. (Specify)	, farm, stre	eet, factory, office		City or Tow	n, State) 1() 2 S	Rural Route Number, Kelly Ave.
	spital ours nere! filled		29a. Certifier 1 ☐ Certifying P	Scene	of my knowled	doe doath	a cooursed at the time		9, ве	1 Alr, Ma	
	Hos Fur Fur stely	edical	(Check only one)	miner: On the basis of and manner sta	examination	and/or inv	restigation, in my opi	nion, death occurred	at the time, o	ause(s) and manner late and place, and d	as stated. ue to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier				29c. License	number	2	29d. Date signed (Mo	nth, Dey, Year)
			Que D:	·			OCME			April 19,	2005
	CK		-,00								-000

State Registrar AMA RUB, LO, MD 31. Date filed (Month, Day, Year) 32. APR 2 2 2005

111 Penn Street Baltimore, Maryland 21201

			1 - For State Registrar		State	of Maryla		artmen rtificate				1ental H	lygien Reg. N	2005	13667	Total
		Ž.	Decedent's Nam	e (First, Midd	lle, Last)	_			-	-		2. Date of			3. Time of Death	-
-	TCTC		John Gil	hert B	Brooks							Month April		ay Year		м
	/Medi Examir				on, give street and nu	ımber)		4b. City,	Town, or	Location	of Death	APILI		2005 c. County of Dea		_
			Genesis E	lder C	are, Coll	ege Vie	ew Ctr.	Fred	eric1	k				ederick		
	Funeral		5. Social Security N		6. Sex		s. last birthday)	If Under	1 Year	If Under		8. Date of I	Birth Vaca	9. Bi	rtholace (State or Foreig	gn
ı	Director		224-48-83	18	1 □X M 2 □ F	67	Yrs.	Months	Days	Hours	Min.	July	13, 1	937 Vir	ountry) 'ginia	
	p ,		Usual Residence of 10a. State			1.0									,	
	anyle •hov	_		10b. County			ity, Town or Lo								10d. Inside City Limit	
	8 - F - F	Sc	MD		erick	F	rederio	ck							¹∏Yes 2□N	0
	with the	吉	10e. Street and Nur	_				10f, Zip					10g. C	itizen of What C	ountry?	
	• 234	by Funeral Director	2616 S.	Everiy					21701					ted Sta		
	er de	Š	11. Marital Status	-1 0011	Armed F			Was Deced If Yes, spec	lent of His ify Cuban	spanic Ori n, Mexicar	gin? (Spe 1, Puerto	ecify Yes or I Rican, etc.)	No-	14. Race - Am Black, Whi		
36	irs eff	2	1 ☑ Never Marri 3 ☐ Widowed		If Yes. G	2□No 9= ive Dates: to 7	15-61	1 ☐ Yes 2	2∏No	Specify:				Specify:		
21215-0036	within 72 hours efter deeth with the Maryland ene. than "naturel", or Iteme 23a or 28a-f ehow ha Madical Examinat must be notified at	ed		15. Deceden	nt's Education	TO /	16e. Dece	dent's Usua	I Occupat	tion			16b #	Kind of Business	Black	_
75	alo 72	Completed		rify only highe	st grade completed)		(Give	kind of won	k done di e retired)	uring mos	t of worki	ng	100. 1	Viria or business	virioustry	
217	T S S S S S S S S S S S S S S S S S S S	E	Elementary/Seco 12	indary (0-12)	College (	1-4or 5+)	Auto	Parts	s Spe	ecial	ist		A11	tomotiv	e Retail	
	ether the	Bec	17. Father's Name	(First, Middle,	Last)							(First, Midd	_		e Recarr	_
Maryland	s 1 and 2 should be filed within 72 hours etter deeth with the Marylan if Heelth end Mantal Hyglene. Item 27 is marked other than "naturel", or Iteme 23a or 28a-f show other traumatic event, the Madical Examiner must be notified at	P B	Charles	Robert	Brooks,	Jr.				Emma	Bre	wer				
ar <sub>Z</sub>	shou ond N	-	19a. Informant's Na	ame/Relations	ship (Type, Print)		19b. Mailir	ng Address	(Street er				ber, City	or Town, State,	Zip Code)	_
Σ	Heelth e tem 27 is		Roland K	. Bass	- Nephew							rederi				
J.	of He item		20a. Method of Disp			20b.	Place of Dispo	sition /Nam	e of	1		ate	-	ocation - City or		-
Baltimore,	permit. Peges 1 end Depertment of Heelth Importent: If Item 27 eny Injury or other t		1 X Burial 2 [ 1 4 □ Donation		3 □Removal from Specify)	State Cu	Ipeper	Natio	naT	' i	4-22	-05	Cu	lnapar	Virginia	
Œ	mit.		21. Signature of Fu			1 0	emetery	. Name and	d Address			0,5	Çü	Thebel,	VIIgInia	_
Ä	Depermination of the permits of the	, j	Klue	M .	Solow	1001	Je	ynes	Fune	ral	Home	, Inc.	77 A	20186		
			23a. Part1. Enter th	ne disease, er	complications that	eused the dea								20100	Approximate	_
	Physician		Immediate Cause (	Final	only one cause on		·	7.16	05	- 1 7		<i>(. 1</i>			Interval Between Onset and Death	
	/Medical		disease or condition resulting in death)	n		OT A CONSEC		18 66	16	13	0 1	57			10 049	)_
н	Examiner					Emisi		8	τα	Ducs					(2 mich	L
		9	Sequentially list cor if any, leading to im	nditions, mediate	D	(or as a consec				6					0 .7411	_
	uted d ansit	直	cause. Enter Under Cause (Disease or that initiated events	injury	6	H4PEN	7845	iue	٤	NIE	PIFA	WT	471	3	6 munth	1
Ó	exec en en riei-tr	Examiner	resulting in death) L	ast	Due to	(or as a consec	quence of):							-		
68760,	cate be executed physicien end the buriel-transit	dicai			d	14 PEN	JENSI	9 N							10 411	
_		Jed ded														_
Вох	deeth certifi e ettending i id for use es	Physician/Me	IF FEMALE: 23b. Was decedent			come of pregna		Ectopic pre						23d. Date of de	livery	
Ξ.	0 0 0	흥	in the past 12 t 1 ☐ Yes 2 ☐			ant at time of c		Other (spe						Month	Day Year	
P.O.	law requires thet the de es been signed by the 2 should be deteched	جُ	9 Unknown													
	es the grand pe de	by	Part II. Other signifi	cant condition	ons contributing to d	eath but not res	sulting in the un	derlying car	use given	in Part I.		23e. Did	tobacco	use contribute to	the cause of death?	
ord	w requir been si should						<u> </u>					10	Yes 2	ZNo 3□Pr	obably 4 Unknown	1
900	e lawre hes be	Completed										24a. Wa		24b. Were au	itopsy findings available completion of cause of	•
Ě	0 - 9	ĕ										per	opsy ormed? 2 X No	death?	2 No	
<u>ta</u>	ucien: Th certificate rector, peg	Bec	25. Was case referm	ed to medical					2	26. Place	of Death	Check only		10163	20140	Ŧ
<b>\$</b>	Physicien: this certific rel director,	To E	examiner? 1 ☐ Yes 2 🔯 i	No	Hospital: 1 🔲	npatient 2	ER/Outpatient	3 DOA	Other:	4 □XNur	sing Hom	ne 5 Res	idence	6 □Other (Spe	cifv)	
0	ding Pi h. After th funerel		27. Manner of Death	5 Pendin	28a. Date	of injury th, Day Yeer)	28b. Time of Injury	28	c. Injury a Work?			8d. Describe				
Ö	Attending ir deeth. ector: After by the funer	ä	2 Accident	investig	gation		.,_,	M		s 2 🗆 N	10					
-		Certification;	3 Suicide 4 Homicide	6 Could r determ	ined 286. Place	of Injury - At he	ome, farm, stre	et, factory,	office		2		(Street en		ıral Route Number,	_
Ω	rs ef	3			ļ			_								
	To the Hospital or Attan within 24 hours after deet To the Funeral Director: completely filled in by the	edical	(Check only	1 ☐ Certifyin 2 ☐ Medical I	g Physician: To the Examiner: On the base	best of my kno	owledge, death	occurred at	t the time,	, date and	place, a	nd due to the	cause(s)	and manner as	stated.	
	the the the	Med	Circy		/ and mani	ner stated.		-								
	5 1 × 10	-	29b. Signature and	THE ST COULIE					License r		2		29d. Dat	te signed (Monti	n, Day, Year)	
	1			144	TUD			D	- 3	191	L		041	18 /	25	
		-		-												
			30. Name and addre					Print)					,		12.13	
			Jugo Men	wan	MD, 156	4 OPO	SSUMT	Print)			net	E Mi	4 1	mp 2	1702	
	Star Registra	te	JUHO MEN 31. Date filed (Month	wan	MD, 156		SSUMT	Print)			NET	e Mi	4 1	mp 2	1702	_

			1 - For State Registrer	Sta	te of Ma	ryland /		artment rtificate				lental H	ygien Rag. N	0000	12000	
	Discorded.		1. Decedent's Name (First, Middle	e, Last)		_						2. Date of D	Death	to the last of the	3. Time of Death	+
	Physici /Medic		Selma Virginia	Board								Month April		<sup>ау Үөаг</sup> 2005	2:45 A <sup>M</sup>	
	Examin	er	4a. Facility Name (If not institution		,			4b. City, 1	Town, or	Location of	of Death		4	c. County of Dea		_
			Wilson Health C					Gait!					1	Montgome	ery	
	Funeral		5. Social Security Number	6. Sex 1 ☐ M 2		(In yrs. last b		If Under	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of E (Month, L	Birth Day, Year	9. Bi	rthplace (State or Foreign country)	7
	Director		577-60-1136 Usual Residence of Decedent		K .	93	Yrs.					Apr.	20,		st Virginia	_
	land ow		10a. State 10b. County			10c. City, To	wn or Lo	cation							10d. Inside City Limits	-
	Mary -f.sh	ţō	Maryland Montgo	merv		Gaith	ereh	ura							1 XYes 2 No	
	the	rec	10e. Street and Number	mery		Gartin	C130	10f. Zip (	Code				10g. C	itizen of What C	ountry?	_
	3a o	i D	301 Russell Ave	ทแค										ted Stat	•	
	deati ms 2	ner	11. Marital Status	12. Wa	s Decedent Ev	ver in U.S.	13.	Vas Decede	ent of His	spanic Ori	gin? (Spe	ecify Yes or N		14. Race - Am		_
ဖွ	after or Ite	Fu	1∑ Never Married 2 Marr	ied 1 🗀	ned Forces? Yes 2X No						n, Puerto	Rican, etc.)		Black, Whi	te, etc.	
8	ours rel',	db	3 Widowed 4 Divorced	Yea	es, Give			I□Yes 2	XT1 NO	Specify:				Specify: Wh	ite	
5-	filed within 72 hours after death with the Maryland Hygiene. uther then "neturel", or Items 23a or 28a-f show ont, I've Medical Exercitive trivist by notified at	Completed by Funeral Directo	15. Decedent (Specify only highes		leted)	16	(Give	ent's Usual	done di	urina most	t of worki	na		Kind of Business	,	_
7	vithin ne. hen	пр	Elementary/Secondary (0-12)	Coll	lege (1-4or 5+		life. I	OO NOT use	e retired)				j.	Dept.		
N N	iled v dygie ther t		17. Father's Name (First, Middle,	(ast)	2	Se	ecre	tary		10 11-11-		· · · · · · · · · · · · · · · · · · ·		ricultu	re 	
and	otal Performal Performant	Be										(First, Middl		n Su <i>mame)</i>		
2	should be nd Mental marked o	<sup>o</sup>	Charles Holley 19a. Informant's Name/Relations		nt)	10	h Mailin	a Address (				Roush	-	T 0::		_
Maryland 21215-0036	d 2 s ith an 27 is treu		William Parsons		•									or Town, State,	Zip Code)	
	Health Health tom 27		20a. Method of Disposition	/ Nepilev	<u> </u>	20b. Place	of Dispo	sition (Name	e of			ston, N	-	ocation - City or	Town State	_
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel", or Items 23a or 28a-f show any injury or other treumettic event, Ite Medical Exertinative netlined at once.		1 ☐Burial 2 ☐Cremation  4 ☐Donation 5 ☐ Other (S)		from State	Pine H		natory or oth			-22-	.05		oley, WV	8.	
	artme orter injur		21. Signature of Funeral Service		<b>)</b> #CCO		T	. Name and				.05	KT	orey, wv		_
ñ	permit. Departr Importe any inju		Morece	1	DO 1 1	11	0	Vai:	1 Fu	nera1	Hon	ne	n - 1	1 5757	05071	
			23a. Part1. Enter the disease or shock, or heart failure.	complications	that caused ti	he death. Do	not ente	or the mode	of dying	, such as	cardiac o	r respiratory	KID_ arrest.	ley, WV	Z5Z/I Approximate	-
	Physician		Immediate Cause (Final	only one caus	e on each line		1 1	. 7 .		1					Interval Between Onset and Death	
	/Medical		disease or condition resulting in death)	a	ue to (or as a	consequence	125 T	VCIIV	حـ	Inu	9	31565	50		10205	
	Examiner		Consensation to the second state of			·	,								,	
	D ==	ner	Sequentially list conditions,  Lary leading to minimize the cause. Enter Underlying Cause (Disease or injury	b. — D	iie to (or as a.	nonsaquence	off)									
	nd	Examiner	that initiated events	c										0		
Š,	e exe sian a urial-	Ë	resulting in death) Last	Di	ue to (or as a	consequence	of):									_
8760	death certificate be executed e attending physician and id for use as the burial-transit	dicai		d												
9 ×	leath certific attending p I for use as	Physician/Me	IF FEMALE:	20- 16					-							
Вох	attend for us	ian	23b. Was decedent pregnant in the past 12 months?	1 0	s, outcome of Live birth 2	Fetal deat		Ectopic pre						23d. Date of de	livery Day Year	
o.	that the de led by the a detached (	ysic	1 ☐ Yes 2 ☑No 9 ☐ Unknown		Pregnant at tir Unknown	me or death	5 🗀	Other (spec	cify)						Juy 1041	
م	that the by detail		Part II. Other significant conditio	ns contributing	g to death but	not resulting	in the un	deriving cau	ISA CIVAR	n in Part I		23a Did	tohaccou	use contribute to	the cause of death?	
Records,	igi be	d by		•				,9	giva.			1		□No 3□Pr		
Ö	w requ	Completed				.,,,,,										_
Ř	The lay	ш										24a. Was		prior to death?	itopsy findings available completion of cause of	
Vital		CO	25. Was case referred to medical				<del></del>					1 ☐ Yes	2 No		2 No	_
	Physicien: this certific ral director,	Ö	examiner?	Hospital:	1 🔲 Inpatient	2 ER/O	utaatioat	2 7 004	Other			(Check only		a. Mari		7
Ö	y Phys er this eral dii	н,	27. May r of Death	28a.	Date of Injury (Month, Day Y		Time of		c. Injury a			ne 5 ∐ Hes 8d. Describe		6 □Other (Spectry occurred	cify)	÷
DIVISION	Attending I r death. ector: After by the funer	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investig		(Month, Day Y	rear)	Injury	М		o es 2.∐N	lo		,	,		
<u> </u>	tel or Attendii s after death. el Director: A ed in by the fu	E	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	ned 280.	Place of Injury building, etc.	· At home, fa	arm, stre	et, factory,	office		2	8f. Location	Street an	nd Number or Ru	ral Route Number,	
5	tefor	Certification:			building, etc.	(Specify)						City or To	wn, State	3)		
	To the Hospitel of within 24 hours at To the Funerel D completely filled in	edical	29a. Certifier 1 Certifying (Check only one) 2 Medical 8	xammar. On	To the best of the basis of ex manner state	xamination ar	e, death nd/or inv	occurred at estigation, in	the time n my opir	, date and nion, death	l place, <i>a</i> h occurre	nd due to the d at the time,	cause(s) date and	) and manner as d place, and due	stated. to the cause(s)	_
	To t withi To tl	Ž	29b. Signature and title of certifier			, .		29c. l	License	number	, 10	×	^	te signed (Monti	n, Day, Year)	_
			1/1/	~ /	00	~~			()·	,40	148		HP	2011/10	2005	
			30. Name and address of person	) olins	ry	9		rint) JUSSC	11 F	fre.	6	aitho	rsbu	m en	d.	
	Stat	_	31. Date filed (Month, Day, Year) APR 2 2	1	32. Registrar's	s Signature	A	- A 3								
	Registra		HER 2 2	/HIII	E 10 -0 2 4 3	4 65	0.1180	ALCOHOL: NAME OF TAXABLE PARTY.								- 1

		1 - State Registrar		aryland / Dep <i>Ce</i>	rtificate of			Reg. No. 201	15 1366
Physici	an	1. Decedent's Name (First, Middle, Las	")				2. Date of De.		3. Time of Death
/Media	al	DANNY ELVI			41.07.7		April	19 200	5 6:20 p <sup>M</sup>
Examir	er	4a. Facility Name (If not institution, give STELLA MARIS HOS				, or Location of Deal	h	4c. County of I	
uneral		5. Social Security Number 6. Se	x 7. Ag	e (In yrs. last birthday	TIMONI  If Under 1 Yea	r If Under 24 Hrs			IMORE Birthplace (State or Foreign Country)
rector		216-74-6433	<b>Š</b> M 2□F	4 0 Yrs.	Months Day	s Hours Min.	July 9		MARYLAND
M H		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or L	ocation			<u> </u>	10d. Inside City Limits
nd other than "natural", or tems 23a or 28a-f show event, the Madical Examinations by notified at	tor	MARYLAND HARFORI	CO CO	ABERDE	?N				1 ☐ Yes 2 🔀 No
Dr 20	Director	10e. Street and Number		TIDDING .	10f. Zip Code			10g. Citizen of Wha	t Country?
T I	rai	678 HOLLY CIRC	CLE		210	01		U.S.A	_
No.	Funerai	11. Marital Status	12. Was Decedent Armed Forces?		Was Decedent of	Hispanic Origin? (Suban, Mexican, Puer	pecify Yes or No to Rican, etc.)	14. Race - /	American Indian, Vhite, etc.
Name of	by F	1 X Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☒ N If Yes, Give Year or Dates:	40	1 ☐ Yes 2 💢 💥 🖟	o Specify:		Specify:	
4	ted	15. Decedent's Edu	ucation	16a. Dece	dent's Usual Occi	upation		16b. Kind of Busin	BLACK
	ple	(Specify only highest grad	le completed) College (1-4or 5	(Give	kind of work don DO NOT use retir	e during most of wo.	rking	100.11.10.01.00.01	ood.nadotty
2	Completed	10th grade		CUSTO	DIAN			LANDSCA	PE
979	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nar	ne (First, Middle,	Maiden Surname)	
aumatic event, I're M	٩	CLARENCE BANKS	0.14	17			A DALLAM		
traur		19a. Informant's Name/Relationship (T)	, ,					or, City or Town, Sta	
or other traumatic	il.	Jay D Banks/Broth 20a. Method of Disposition		20b. Place of Dispe	sition (Name of		erdeen, l	Md., 2100. 20c. Location - City	
y or		¥ Burial 2 ☐ Cremation 3 ☐ F  '4 ☐ Donation 5 ☐ Other (Specify)			matory or other pl	. !			
any injury or once.	1	21. Signature of Funeral Service Licens		BEREKLEY	Name and Add	ross of Facility	23-05		ON, MARYLAND
any ir		Bru Ald		WN	IC BROWN	N COMMUNI: ILADELPHIA	Y FUNERA	AL HOME-HA ABERDEEN,	ARFORD, P.A.
		23a. Part1. Enter the disease, or compleshock, or heart failure. List only of	ications that caused	the death. Do not en					Approximate Interval Between
ian		Immediate Cause (Final disease or condition	a. LIVER	CANCER					Onset and Death
cal ner		resulting in death)		a consequence of):			-		
	6	Sequentially list conditions, if any, leading to immediate	Due to (or as a	a consequence of):					
	aminer	cause. Enter Underlying Cause (Disease or injury							
	Exa	resulting in death) Last	Due to (or as a	a consequence of):					
s the burnal-tr	cai		d						
2	Physician/Medical	IF FEMALE:						-	
200	ian/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome 1 Live birth	2 Fetal death 3	Ectopic pregnan	су		23d. Date of Month	delivery Day Year
	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□Unknown	time of death 5L	Other (specify)				July 1 July
0		Part II. Other significant conditions con	ntributing to death bu	it not resulting in the u	nderlying cause g	iven in Part I.	23e. Did to	bacco use contribut	a to the cause of death?
eg pin	ed by						1 □ Y	es 2□No 3□	Probably 4 XUnknown
pinous	Completed						24a. Was a	an 24b. Were	autopsy findings available
page 2	E						autops	med? prior death	to completion of cause of
5	BeC	25. Was case referred to medical				26. Place of Dea	1 ☐ Yes th (Check only or		′es 2□No
5	0	examiner? 1 ☐ Yes 2 <b>X</b> No	fospital: 1  Inpatie	nt 2 ER/Outpatier	t 3 DOA	ther	ome 5 Reside		Specify) HOSPICE
	ou:	27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Injur (Month, Day	y 28b. Time o Year) Injury		ury at ork?	28d. Describe h	ow injury occurred	1051101
D .	cati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	00 DI (1)			]Yes 2∏No			
in by	Certification;	4 Homicide determined	28e. Place of Inju building, etc	ry - At home, farm, str . (Specify)	eet, factory, office	•	28f. Location (Si City or Town	treet and Number or n, State)	Rural Route Number,
pellij		29a. Certifier 1V Certifying Phys	sicien: To the best of	f my knowledge, deatl	Occurred at the t	time date and place	and due to the -	auco/c) and	as stated
completely filled in by	edicai	(Check only 2 Medical Exeminate)	ner: On the basis of and manner sta	examination and/or in	estigation, in my	opinion, death occu	red at the time, d	ate and place, and o	due to the cause(s)
сошр	Me	29b. Signature and title of certifier	·			se number		9d. Date signed (Mo	onth, Day, Year)
		100			D	43725		4/20	105
		1							

Registrar
DHMH 17 Rev 1/2001

State

DR. TARIQ MAHMOOD

31. Date filed (Morith, Day, Year)

APR 2 2 2005

2300 DULANEY VALLEYR D. TIMONIUM, MD 21093
32 Peĝistrar's Signature

			For State Registrar	State of Marylan		nent of F			ene . N2 0 0 5	3670
	Physici /Medic Examir	cal	4a. Facility Name (If not institution, give	BraxToN street and number)	4b.	City, Town, o	r Location of Death	2. Date of Death Month April	Day Yea	5 2:3 <sup>M</sup>
	Funeral Director		5. Social Security Number 6. Se 216 - 30 - 6608	Parkway  7. Age in yrs.  68		Joder 1 Year onths Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	(ear) 9. E	Birthplace (State or Foreign Country)
	e Maryland 3a-f show Lifted at	Director	Usual Residence of Decedent  10a. State 10b. County  N/A		y. Town or Location					10d. Inside City Limits 1 ☐ Yes 2 ☐ √o
"	be filed within 72 hours after death with the Maryland tal Hygiene. dother then "neturel", or liems 23a or 28a-1 show event, The Medical Exert at most less realised at	Funeral Dire	1501 W · Mos  11. Marital Status  1 Never Married 2 Married	her St.  12. Was Decedent Ever in U. Armed Forces?  1 □ Yes 2 ② No	S. 13. Was I	_	lispanic Origin? (Sp an, Mexican, Puerto		g. Citizen of What  US  14. Race - Ar  Black, WI	Anerican Indian,
21215-0036	within 72 hours a ene. then "neturel", or	Completed by	3 Widowed 4 Divorced  15. Decedent's Ed. (Specify only highest grace	If Yes, Give Year or Dates:	16a. Decedent's (Give kind life. DO N	of work done OT use retired	during most of work d)	ing	Specify:	•
Maryland 21	rould be filed with I Mental Hygiene. Parked other then natic event, ILED	To Be Con	17. Father's Name (First, Middle, Last)  Tames Hend	)erson			Bess	e (First, Middle, M	4 °C10	s d
	1 and 2 sho Health and Bm 27 is m ther treum		19a. Informant's Name/Relationship (T) Rita Hollie Silve 20a. Method of Disposition	r/Daughter	1554	S h		Road	•	815150
Baltimore,	permit. Pages Department of I Importent: If It eny injury or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ F  '4 ☐ Donation 5 ☐ Other (Specify  21. Signature of Funeral Service) Cens	Removal from State	emetery, cremator 22. Nar	ndel Pa	N 4/22	105 1	Baltimore Pravice, F	County, MD P. A. 21206
	Physician /Medical		23a. Part1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)	lications that caused the death ne cause on each line.  a. Due to (or as a consequence)	- Cenal	mode of dyin	g, such as cardiac	or respiratory arres	t,	Approximate Interval Between Onset and Death
8760,	Examiner  bhysician and  the burial-transit	Ical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. — Due to (or as a consequence.  Due to (or as a consequence)	uence of j.					
P.O. Box 68	death certif	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregna 1 Live birth 2 Fetal 4 Pregnant at time of di 9 Unknown	I death 3 □Ecto	pic pregnancy ar (specify)			23d. Date of d Month	lelivery Day Year
Records, P.	law requires that the as been signed by th 2 should be detache	by	Part II. Other significant conditions co	ntributing to death but not resurred Vascov	ulting in the underly	ring cause giv	en in Part I.		2 No 3	to the cause of death? Probably 4 Unknown
Vital Rec	The ate ha	e Completed	25. Was case referred to medical				26 Place of Deat	24a. Was an autopsy performed 1 Yes 2	prior to	
n of	ng Phys fter this meral di	atlon: To B	evaminer?	Hospital: 1   Inpatient 2   28a. Date of Injury (Month, Day Year)	ER/Outpatient 3[ 28b. Time of Injury	DOA Oth  28c. Injun Wor  1	er: Nursing Ho		ce 6 Other (Sp	ресіђу)
Division	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Certification:	3 Suicide 4 Homicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specify	/) 			City or Town,	State)	Rural Route Number,
	the Hos	Medical		sician: To the best of my kno iner: On the basis of examinal and manner stated.			pinion, death occur	red at the time, dat		ue to the cause(s)
	¥ 3 ¥ 8	_	Thank Te	relong	mo	DO	059423	. F	port 19	2005
3	٧		30. Name and address of person who co	Good Sama	itan Hos	portal	Professione	f Bushli	#303 Page	brown MD
	Sta Registr		31. Date filed (Month, Pay Year) 2	2005 32. Redistrar's Signa	ture	when the same				2/239

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. item#18, perFH, G842, 4/26/05 TT State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** ELAINE BOKOR APRIL 20 2005 8:30 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 130 SLADE AVENUE APT. # 521 BALTIMORE BALTIMORE 7. Age (In yrs. last birthday) If Under 1 Year Months Days If Under 24 Hrs. 8. Date of Birth 08/16/1922 9. Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1 □ M 2 🛛 F 82 141-32-6721 HUNGARY Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show sust be notified at 1 ☐ Yes 2√ No Director MD BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 130 SLADE AVENUE APT. #521 21208 or Items 23a U.S.A. Funeral . Was Decedent Ever in U.S. Amed Forcee? 1 Yes 2 No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 7 le markad other than "naturel", or Items treumatic event, the Mydical Examiner. 2 should be filed within 72 hours after a and Mental Hygiene. I e markad other than "naturel", or Itel 1 Never Married 2 Married Baltimore, Maryland 21215-0036 WHITE 1 ☐ Yes 2 No Specify: Specify: à 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) OWNER **JEWELRY** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First Michile, Maiden Sumame) Be WELTLINGER BARON MIHALY 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JUDY BERMAN/DAUGHTER f Health 3305 GARRISON FARMS ROAD BALTIMORE, MD 21208 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition ō Department of Importent: If It any injury or conce. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State OHEB SHALOM MEMORIAL 04/21/2005 REISTERSTOWN, MD '4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Approximate Interval Between Onset and Death 23a. Part I. Egrer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on jach line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions Due to for as a consumence of Tary, leading to immedicause. Enter Underlying Cause (Disease or injury that initiated events Examiner attending physician and for use as the burial-transit To the Hospitel or Attending Physicien: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Live birth 2 Fetel death Month Year in the past 12 mont Day 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☑ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. þ 3 Probably 4 □Unknown 1 Yes 2 No Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Medical Certification: 1 Natural s after dec. 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day

			For State Registrar	State of M	arylan		artment of H			giene	)5	13672
			1. Decedent's Name (First, Middle,	Last)					2. Date of De Month	aath Day	Year	3. Time of Death
	Physici		David A.	Bower	3				041		005	4:25 AM
	/Medic Examin		4a. Facility Name (If not institution,				4b. City, Town, or	Location of Death		4c. County		
	Examili	CI .		RITAN HO		AL	B	ALTIM	DRE	N	/A	
	Funeral					ast birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Bir (Month, Da	rth	9. Birthp	lace (State or Foreign
	Director		215-78-9502	1 <b>X</b> M 2□F	45	Yrs.	Months Days	Hours Min.		7. 1959		
	_		Usual Residence of Decedent									
	yland		10a. State 10b. County		10c. City	, Town or Lo	ocation				1	0d. Inside City Limits
	Mar Har	to	Maryland Balt	imore	Dui	ndalk						1 ☐ Yes 2 ☐ No
	128e	rec	10e. Street and Number				10f. Zip Code			10g. Citizen of V	hat Cour	ntry?
	72 hours after death with the Maryland natural', or Items 23s or 28s-1 show dest Evaculaer must be notified at	Funeral Director	7300 Martell Av	enue			2122	22		United	Stat	92
	ns 2	era	11. Marital Status	12. Was Decedent		S. 13.	Was Decedent of Hi If Yes, specify Cuba		ecify Yes or No	o- 14. Race	- Americ	an Indian,
10	fler of the control o	Fur	1√2 Never Married 2 Marrie	Armed Forces? d 1 ☐ Yes 2-☐ If Yes, Give					Rican, etc.)		k, White,	
33	urs a		3 ☐ Widowed 4 ☐ Divorced	Year or Dates:			1 ☐ Yes 2八 No	Specify:		Specify	. Wh	ite
5-0036	2 ho	Completed by	15. Decedent's	Education		16a. Dece	dent's Usual Occupa	ation	ina	16b. Kind of Bu	siness/In	dustry
15	n n	ple	(Specify only highest Elementary/Secondary (0.12)	College (1-4or	54)	life.	DO NOT use retired	)	ing			
2121	within jiene. r than "	E	12 years	Conlogo (1 voi	.,	Crab	Steamer			Food		
b	filed Hygid other ent,	၁ ဓ	17. Father's Name (First, Middle, La	ist)				18. Mother's Name	e (First, Middle	, Maiden Sumam	e)	
an	Mental Mental Sarked or	To Be	Richard O. Bowe	rs				Cather	ine M.	Young		
Maryland	2 should be filed within and Mental Hygiene. Is marked other than aumatic event, the Mannatic event, the Mannatic event, the Mannatic event.	-	19a. Informant's Name/Relationshi	o (Type, Print)		19b. Maili	ng Address (Street a	and Number or Rura	al Route Numb	er, City or Town,	State, Zip	Code)
<b>S</b>	id 2: Ith air 27 Is		Catherine Bower	s (Mother)		7300	Martell	Avenue	Dundal	k, Maryl	and	21222
a)	1 an Hea Hea Sther	1	20a. Method of Disposition	S (FIOCHEL)	20b. P	lace of Disp	osition (Name of		Date	20c. Location -	City or To	own, State
٥	nt of nt of nt of nor or		1 ☐ Burial 2 ☐ Cremation 3			-	matory or other plac Cemetery	1	/2005	Baltimo	re.	Maryland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Deperfirment of Heatih and Mental Hygiene. Importants if item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, its Medical Evantual must be routhed at DDCs.		* 4 □ Donation 5 □ Other (Special Signature) of Funeral Service Li		Oas	-	2. Name and Addres		2003	Darcino	10,	riar y rana
Bal	Depe Impo any ii		21. Signature of Pulleral Service Li				Duda-Ruck	Funeral	Home o	f Dundal	k, I	nc.
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	signed to be det	by F	Part II. Other significant condition	-		~					. /	ne cause of death?
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ta	Physician: The this certificeteral director, pag	Be (	25. Was case referred to medical examiner?					26. Place of Deat	h (Check only	one)		
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Division of Vital	fter ne	Certification:	27. Manner of Death  Natural 5 Pending		ury ay Year)	28b. Time o Injury	Work	y at k? Yes 2 □ No	28d. Describe	how injury occurr	ed	
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Ξ	or At	it.	4 Homicide determin	building, e	tc. (Specif	y)	iledi, laciory, omoo			wn, State)		
	To the Hospital or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	edical Ce	29a. Certifier 1 Certifying (Check only 2 Medical E	Physician: To the bes xaminer: On the basis and manner s	of examina	wledge, dea tion and/or i	th occurred at the tin envestigation, in my o	ne, date and place, pinion, death occur	and due to the red at the time	e cause(s) and ma , date and place, a	nner as s and due to	tated. the cause(s)
	ithin o the	Me	29b. Signature and title of certifier				29c. Licens	e number		29d. Date signed	(Month,	Day, Year)
	F 3 F ŏ	1	Comman	MI	) .		DODE	60687		04/	18/	2005
7	1		30. Name and address of person w	the completed cause of	death /Iten	23a) (Tune						
3	('		30. Name and address of person w	to MAS M		77-1	10011	RAVENI	BLUC	BALT	7 10	DRE 21239
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ě	ji e	4	Saint Josep  5. Social Security Number			last birthday)	If Under	1 Year	If Under		8. Date of Birt	th			. M O ∩ € ce (State or Foreign
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	ryland how		10a. State 10b. County		10c. Ci	ty, Town or Lo	cation							100	d. Inside City Limits
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920	urs af	by	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Date	WW	II	1 🗆 Yes	2 XNo	Specify:				Specify:	Whi	te
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Ma	d 2 s th an th an 27 is r treur		Deborah C. Cus:		er)		Vande				atonsvi	•			•
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Вох	death certifica e attending ph d for use as t	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom			Ectopic pr	eanancy				2	3d. Date o		
	0 9 8	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregnan 9□Unknow	t at time of c		Other (sp						Month	D	ay Year
P.O.	that the do	hys	9 Unknown												
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orc	w require been si should I	sted											140 31		ory 4 DONKHOWN
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	Hospital 24 hours a Funerel E		29a. Certifier Cartifyin	ng Physician: To the be Examinar: On the basi	est of my kno	owledge, deat	h occurred	at the tim	e, date an	d place, a	and due to the d	cause(s) a	and manne	er as stat	ed. Cy, MD
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	To To Com	Z	29b. Signature and title of certifier	r			290	. License	number			PULL	signed (A	70.5 70.5	ay, rear)
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1	15)		30. Name and address of person	who completed cause of											
	Sta	to.	31. Date lied (Month, Day, Year)	HRNER M. P.	istrar's Sign	toge OSL	ER-D	RIVE	<del>- 10</del> 1	<del>JSON</del>	MARYL	AND	210	4714	
	Registr		APR 2 1 2005		is so	perti									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month 9:35 P tudreu 2005 6 /Medical 4a. Facility Name (If not institution give street and number)
Baltimore VA. Medical 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimor If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1**X** M 2□ F Director 236-24-8275 <u>West Virginia</u> Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f show other traumetic event. If a Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Baltimore Middle River 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after deeth with to nent of Heatth and Mental Hygiene. ont: If item 27 Is marked other than "neturel", or Items 23a or; 405 Bowleys Quarters Road 21220 Completed by Funeral U. S. A. 12. Was Decedent Ever in U.S. Armed Forces?

12 Yes 2 No
1f Yes, Give 104
Year or Dates: 194 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1043 1 ☐ Yes 2X No Specify: 3 ☐ Widowed 4 ☐ Divorced 1945 White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Trucking Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Andrew Bentley Callison Mary Lynn Anderson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21220 Middle River, Maryland Mary Louis Callison (Wife) 405 Bowleys Quarters Road 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Department of Importent: If any injury or once. <sup>¹</sup> 4 □ Donation 5 □ Other (Specify) Wallace Memorial Cem. 04/23/2005 Clintonville, West Va. 22. Name and Address of Facility Fruzdzinski Funeral Home PA 1407 Old Eastern Avenue Es 21. Signature of Funeral Service Licenses Ecclarel 23a. Part. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Essex, Maryland 21221 Approximate Interval Between Onset and Death Immediate Cause (Final Sepsis Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying scites Examiner Due to (or as a consequence of): burial-transit or Attending Physicien: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): To Be Completed by Physician/Medical for use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day 4 Pregnant at time of death signed by the aid d be detached for 5 Other (specify) 1 Yes 2 No 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 2□ No 2 **X**No 1 🗆 Yes bucyto □ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Hnpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) After thi funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident hours after death illed in by the 6 Could not be 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a
To the Funerel I
completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month. Dav. Year) 29b. Signature and title of certifier 29c. License number

Registrar

State

31. Date filed (Month, Day,

Baltimore, Maryland 21215-0036

P.O. Box 68760

of Vital Records,

Division

01

2005 Register's Signature

30. Name and address of person who completed cause of death frem 23a) (Type, Print)

A44176435

Guty.

			1- For State State State State of Maryland / Department of Health Certificate of Deal			2005	10070
	0		Registrar  1. Decedent's Name (First, Middle, Last)	2. [	Reg. No.		3. Time of Death
	Physic /Med		Angela F. Colaianni	A	Month oril 2	) 2005	12:05 AM
	Exami		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location	tion of Death	_	c. County of Death	•
	Funeral	-		der 24 Hrs. 8. [	Date of Birth	BACTIMO 9. Birtho	Place (State or Foreign
	Director		213-16-3309 1 M 20 F 9 Yrs. Months Days Hour	urs Min.	Month, Day, Yea	MAR	place (State or Foreign http)
	land		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			11	0d. Inside City Limits
	Mary a-f sh	ctor	MD BALTIMORE Luthervil	lle			1 □Yes 2 No
	deeth with the Maryland ms 23e or 28a-f show (must be notified at	Director	10e. Street and Number 10f. Zip Code	07	10g. (	Citizen of What Cour	ntry?
	ns 23e	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic	Origin? (Specify	Ves or No-	14. Race - Americ	ean Indian
	or Item		Armed Forces? If Yes, specify Cuban, Mexi		n, etc.)	Black, White,	etc.
	003 hours	d by	3  Widowed 4 □Divorced Year or Dates: 1 □ Yes 2 No Spec	спу:		Specify: wh	
	215-	Completed	15. Decedent's Education (Specify only highest grade completed)  [Second only highest grade completed]  [Second only highest grade completed]  [Second only (Second only (Seco	most of working	16b.	Kind of Business/In	dustry
	212 ad with giene er the	Com	Elementary/Secondary (0-12) College (1-4or 5+) Case Weeker, As	sociate	Sto	ate of M	ARYLAND
	and tbe fill ntal Hy ed oth	Be		lother's Name (Fire	rst, Middle, Maide	en Sumame)	
	Maryland 21215-0036 at 2 should be filed within 72 hours aft the and Mental hygiene.  It is marked other then "naturel; or treumatic event; the Madical Exami	P	HOGELO FILG DELFIA  19a. Informa It's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Nur	umber or Rural Roi	ute Number, City	or Town, State, Zip	(Code)
	nore, Maryland 21215-0036 ges 1 and 2 should be filed within 72 hours after deeth with the Marylan to of Health and Mendal Hygiene. If item 27 is marked other then "naturel", or items 23e or 28a-f show or other treumatic event, the Modical Examiner must be notified at		Joseph C. Colgianni-SON 1036 Jamie DON	21	Lither	rville M	D 21093
	Baltimore, M permit. Pages 1 and 2 Department of Health Importent: If Item 27 eny injury or other tre page.		20a. Method of Disposition  1 ABurial 2 Cremation 3 Removal from State  20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c.	Location - City or To	own, State
	altim mit. Paramen autmen ortent: injury		"4 Donation 5 Other (Specify) Gardens of Faith (PM.		05 K	oserlale	MA
	Balt permit. Departr Import eny inji		21. Signature of Funeral Service Licensee 22. Name and Address of Fa	BALTI		MD 2123	54.
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such shock, or heart failure. List only lone cause of each line.	h as cardiac or res		THE COL	Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition	1			Onset and Death
	/Medical Examiner		resulting in death)  Due to (or as a con-equence of):				V
	DAME OF	jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disass or Injury that initiated events				
	xecuted and Il-transit	Examiner	Cause (Disease of Injury that initiated events resulting in death) Last  Due to (or as a consequence of):				
	18760, cate be executed physician and the burial-transit		Due to (or as a consequence of):				
	687 ifficate g phys	edicai	d				
	Cert	hysician/Me	IF FEMALE: 23b. Was decedent pregnant in the acts 13 months?  23c. If yes, outcome of pregnancy  1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy			23d. Date of delive	•
	Records, P.O. Bc The law requires that the death the has been signed by the atter tage 2 should be detached for u	ysici	in the past 12 months?  1 \( \text{Yes} \) 2 \( \text{MNO} \) No  9 \( \text{Unknown} \) Unknown			Month	Day Year
	ds, P.O.  iries that the d  signed by the d be detached	۵.	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pa	art I.	23e. Did tobacco	use contribute to the	e cause of death?
)	Records, he law requires to has been signed ge 2 should be considered.	ed by			1 🗌 Yes	2. ØNo 3□Prob	ably 4 □Unknown
	ecor law requ as been 2 shoul	Completed			24a. Was an autopsy	24b. Were auto	psy findings available impletion of cause of
	Vital Re			1	performed? 1□ Yes 2Ū N	death?	
'	of Vital Physician: T	o Be	examiner?	Place of Death (Chi		6 Other (Specify	la ^
	g Physical this neral di	15	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at		Describe how inj		Mespice
	Division  Tor Attending after death. Director: After	Certification;	2 Accident investigation M 1 ☐ Yes 2	2 🗆 No			
	or Att after d Direct in by	ertiffe	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. L	ocation (Street a City or Town, Sta	and Number or Rura te)	l Route Number,
	Hospitel or 24 hours after Funerel Diru tely filled in I		29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date	e and place, and d	fue to the cause(	s) and manner as st	ated.
)	Division of Vital Re To the Hospitel or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate the completely filled in by the funeral director, page	ledical	(Check only 2 Medical Examiner: On the basis of examination and/or investigation in my entirior	dooth accurred at	also along algana	and almost a mail along the	the cause(s)
	To I To I	Σ	29b. Signature and title of certifier  29c. License number  D=32	oer A 2	29d. D	ate signed (Month,	Day, Year)
	4		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	٧ 5	Mp	in 21 2	-003
	20		29b. Signature and title of certifier  29c. License number of the data of title of the data of title of the data of title of the data of title of the data of title of the data of title of the data	Baltims	r in t	21204	
	St Regist	ate	31. Date filed (Month, Day, Year) APR 2 2 2005				
	negisi	गुद्धाः	THE PERSON ASSESSMENT OF THE PERSON ASSESSMENT				

#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Lest) 2. Date of Death Month 5:15 P.M. April 17, RUTH CROCKETT Η. 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street end number) Alice Byrd Tawes Nursing Home Crisfield Somerset 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months Days Hours Min 1 □ M 2 🗓 F Yrs. 88 225-06-0992 December 14, 1916 Virginia Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Virginia Accomack Tangier 1 ⊠ Yes 2 □ No 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 23340 4375 Parsonage Lane U.S.A. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status ☐ Yes 2 🔀 No Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White 3 XWidowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker At Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Elmer Parks Susie Laird 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Dennis J. Crockett (Son) P. O. Box 81 - Tangier, VA 23440 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Private Family Cemetery 4/21/05 Tangier, VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Robert 11/2 Bradshaw & Sons Funeral Home Robert H. Bradshaw, Jr. 306 W. Main St. - Crisfield, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximate Interval Betw Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of) Due to (or as a consequence of): Part II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobecco use contribute to the ceuse of deeth? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings aveilable prior to completion of cause of deeth? 24a. Was an autopsy performed? 1 Yes 2 2 X11 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 3□ DOA

**Physician** /Medical Examiner

**Physician** 

/Medical

Director

Funerai

þ

Completed

Be

8

10a. State

Examiner

**Funeral** 

Director

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health end Mental Hygiene. Importent: If item 27 is marked other then "neture!" or the treumetic event.

Physiclan/Medical Examiner ettending physician and for use as the bunel-transit ģ Be

Completed Medical Certification: To 27. Manner of Death

page 2 should s efter death.

i Director: Aft
ed in by the ful To the Hospital within 24 hours e To the Funerel C completely filled

or Attending Physicien: The law requires that the death certificate be executed

Hospitai

Division of Vital Records, P.O. Box 68760,

State Registrar

29b. Signature and title of certifier

28a. Date of Injury (Month, Day Year)

1 Certifying Physiclen: To the best of my knowledge, death occurred et the time, dete and place, and due to the ceuse(s) and manner as steted.

| Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

D 48098

28c. Injury et Work?

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year) 118/2005

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print)

Vijay Karumbunathan, M.D. - 201 Hall Highway - Crisfield, MD

31. Date filed (Month, Day, Year)

2 Accident

4 ☐ Homicide

3 ☐ Suicide

29a. Certifier (Check only one)

APR 2 2 2005

5 Pending investigation

6 ☐ Could not be determined



28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene?

			For State Registrar	St	ate of Ma	ryland / D	epartm C <i>ertific</i>	ent of I ate of	Health and Death		giene () () Reg. No.	)5   3677	
1	Physic /Medi		Decedent's Name (First, I	Middle, Last)	Mack	S. Chee	k, Jr			2. Date of De		3. Time of Death	
	Examir		4a. Facility Name (If not institution, give street and number) Sinai Hospital of Baltin			timore						f Death	
	Funeral Director		5. Social Security Number 074-48-3684	6. Sex 1 □ <b>x</b> M		(In yrs. last birth	day) If Ui Mon	ths Days		. (Month, Da	th ly, Year) 2, <b>196</b> 0	Birthplace (State or Foreign Country)     New York	
K	aryland show	2	Joual Residence of Decedent  0a. State 10b. County 10c. City, Town or Location  Md. N/A Baltimore								10d. Inside City Limits 1 X Yes 2 □ No		
40	ith the M or 28a-f	Olrecto	10e. Street and Number	and Number			10f. Zip Code				10g. Citizen of What Country?		
0	death w ms 23a cmust b	Jerai [	3321 A Dolfield Avenue  11. Marital Status  12. Was Decedent Eve			ver in U.S.	er in U.S.  13. Was Decedent of Hispanic Origin? (Specify Yes or N If Yes, specify Cuban, Mexican, Puerto Rican, etc.)					U.S.A. o- 14. Race - American Indian,	
ack	and 21215-0036 be filed within 72 hours after death with the Maryland tal Hyglene. Indicate than "natural", or items 23a or 28a-f show event, the Medical Evaminar must be notified at	by Funeral Director	1 Never Married 2 3 Widowed 4 Divo	Married 1	med Forces? ☐ Yes 2 1 No Yes, Give Year or Dates:	o		specify Cub es 2 <b>⊡x</b> No		to Rican, etc.)	Black,	, White, etc. Black	
£	215-0 thin 72 ho e. an "natur Medical	Completed	(Specify only I	edent's Education	npleted)		Give kind o	Usual Occup f work done OT use retire	during most of wa	rking	16b. Kind of Busi	•	
a	CA B B B P	Com	Elementary/Secondary (0- 12 17. Father's Name (First, Mi		ollege (1-4or 5-	+)		Maintena	ance Engine		Wyl Maiden Sumame	ndham Hotel	
3	Maryland Id 2 should be fill th and Mental Hy It's marked oth traumatic event	To Be	Mack S. Cheek Sr								ine M. McCoy		
Ž	C = '4 =		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  Cathy Miller-Cheek  3321A Dolfield Avenue Baltimore, Md. 21215								tate, Zip Code)		
lation known	Baltimore, oemit. Pages 1a Department of Hes Moortant; if Item any injury or other page.		20a. Method of Disposition 1   XBurial 2 □ Crema 1 □ Donation 5 □ Oth		val from State	20b. Place of cemetery	crematory	or other pla		Date 04/23/05		ity or Town, State	
35	Baltimor permit. Pages Department of h Important; if its any injury or of once.		21. Signature of Funeral Service Licensee  22. Name and Address of Facility  Estep Brothers Funeral Service										
Do	- 402 0		23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between										
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	68760, ficate be executed physician and s the burial-transit	edicai Exan	that initiated events ' resulting in death) Last	d	Due to (or as a	a consequence of	):						
	O. Box ( ne death certif the attending thed for use a	Physician/Mec	IF FEMALE: 23b. Was decedent pregnar in the past 12 months? 1 \( \text{Yes} \) 2 \( \text{No} \) 9 \( \text{Unknown} \)	1 4	yes, outcome o	2 Fetal death	3 □Ectop 5 □ Othe	ic pregnanc r (specify) _	;y		23d. Date Monti	,	
	cords, P. ( w requires that the been signed by should be detected.)	ed by Pr	Par II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?  1 Yes 2 No 3 Probably 4 Inknown										
	Division of Vital Records, i or Attending Physician: The law requires that death. Director: After this certificate has been signed in by the funeral director, page 2 should be or	Completed by	autopsy pnor to cor performed? death?  1 Yes 2 Loo 1 Yes								ere autopsy findings available or to completion of cause of ath?		
	of Vital Rephysician: The this certificate had director, page	To Be	25. Was case referred to medical examiner?  1  Yes										
	ion c inding P ath. r: After t	ation:	27. Manner of Death  1 Natural 5 Pending (Month, Day Year)  28a. Date of Injury 28b. Time of Injury 4 Work?  2 Accident investigation  28d. Describe how injury occurred  1 Yes 2 No										
	Divis	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)										
	Division O' To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical C	29a. Certifier (Check only one)  Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
	To the within To the comple	Me	29b. Signature and title of c	- 1	7/	1//		29c. Licen:	se number	17	29d. Date signed (	(Month, Day, Year)	
	1/		30. Name and address of pe	erson who comple	ated cause of de	(Item 23a) (T	ype Print)	. 1	7//	) 01	Hml	11, 6005	
	, ,	tate	31. Date filed (Month, Day,	tt, N	32. Registra	Signature	Plo	Spit	al=3	Dalti	more,	MIQ.	
	Regis	trar		ADD 99	2009	Madres 6	The Road	Dark					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] 5 1 - For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician 18101 4c. County of Death ArTHUM Apri /Medical 4a. Facility Name (If not institution, give street and number, Examiner 4b. City. Town, or Location of Death Baltimore 2558 North Snyder Avenue Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 XM 2 ☐ F Months Days Hours Yrs Director 24, 1930 Florida 266-36-1142 74 Sept. Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or itama 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be negliged as once. 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 27 No Director Baltimore Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2558 North Snyder Avenue 21219 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 GJYes 2 □ No If Yes, Give Year or Dates: Kore Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No White Specify. δ Korea 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 9\_years Machinist Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Charles Arthur Campbell Mary Lee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2558 North Snyder Avenue Linda J. Campbell (Wife) Baltimore, Md. 21219 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 5 Other (Specify) Militop Service Corp. 4/19/2005 Towson, Maryland ' 4 □ Donation Veral Service See 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Avenue Dundalk, Maryland 21222 23a. Part1. Enter the disease, or complications that causes it shock, or heart failure. List only one cause on each jude Approximate Interval Between Onset and Death death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Terioscleno Candiovascular Physician loxeans disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, Isaumy to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner ig physician and as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physiclan/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) ed by the detached 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown been signal Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an ate has b autopsy perform certificate 1□ Yes 2♥No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner?
1 XYes 2 □ No Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 2 4 Nursing Home 5 Residence 6 □Other (Specify) After this funeral of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Certification: Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No Director: 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🔲 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 29a Certifie Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

DHMH 17 Rev 1/2001

29b. Signature and title of certifier

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who completed cause of death (Item 23a) (Type, Print) MILE Trimble

32. Registrar's Signature 31. Date filed (Month, Day, Year)

Bear H Sperk

29c. License number

Hill CT. Lutherville, MD

29d, Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien® For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Christopher Eiler, Jr. 20, 2005 April /Medical 4:17 pm4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 4c. County of Death Harford Memorial Hospital Havre de Grace
If Under 1 Year | If Under 24 Hrs. Harford 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year Months Days 8. Date of Birth (Month, Day, Year) **Funeral**  Birthplace (State or Foreign Country) Hours 1໘M 2□F Director Yrs. 215-32-4431 70 1, 1934 Maryland August Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location ir than "natural", or items 23a or 28a-f show the Medical Expenier must be notified at 10d. Inside City Limits Directo 1 ☐ Yes 💥 No Maryland Harford Joppa 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1400 Stockton Road Funeral 21085 S. A.

14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Be Completed by 3 ☐ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry othar than Elementary/Secondary (0-12) College (1-4or 5+) 12 Guard - Corrections County Jail 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 should be finance and Mental H is markad ဥ Ernest Christopher Eiler, Sr. Anna May Forester 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: if itam 27 is any injury or othar trau Catherine E. Altmeyer (Sister) 922 Orems Road Essex, Maryland 21221 Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) Oak Lawn Cemetery Baltimore, Maryland 21. Signature of Funeral Service Licensee <sup>22. Name and Address of Facility</sup>
Bruzdzinski Funeral Home PA
1407 Old Eastern Avenue Es 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Essex, Maryland 21221 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed Due to (or as a consequ Completed by Physician/Medical Box ( IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month 4□Pregnant at time of death 5 Cher (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ś 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Hospital: Certification: To Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No 2 Accident Diractor: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after d To tha Funarai Diraci completely filled in by 4 Homicide The Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Ye

32 Bagistrar's Signature

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

MO

70716

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BARMORA

20101

State Registrar 29b. Signature and title of certified

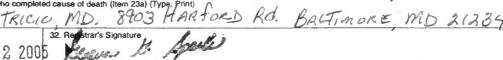
V.

GRACILO

PA 31. Date filed (Month, Day, Year) 32. Redistrar's Signature 2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1.6.1.



29c. License number

008358

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Month **Physician** Year Albert Lawrence Ewing, Sr. 18, April 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Franklin Square Hospital Rossville
If Under 1 Year | If Under 24 Hrs. Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Days Hours 1⊠M 2□F Yrs 216-26-7292 65 Sept. 5, 1939 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director Maryland Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8517 Kavanagh Road Completed by Funeral 21222 United States 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2√ Married 1 ☐ Yes 2X No Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 10 years Steel Worker Steel 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ John Ewing Teresa Guntiner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Melva K. Ewing (Wife) 2517 Kavanagh Boad Dundalk, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Sacred Heart of Jesus Cem. 4/22/05 Dundalk, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 23a Part 1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate interval Between Onset and Death Onset and Death lester Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to infine date cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

Pnysician /Medical Examiner

**Funeral** 

Director

or than "natural", or items 23a or 28a-f show the Modical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after a Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or item any injury or other traumatic event, the M. dicul Ferrespons.

Baltimore, Maryland 21215-0036

use as the burial-transit After Director: /

The law requires that the death certificate be executed

Box 68760.

P.O. P

Division of Vital Records.

Be Completed by Certification: To Medical

24 hours a

25. Was case referred to medical 27. Mann of Death

1 Yes 2 No

2 Accident

3 Suicide

(Check only one)

29b. Signature and title of certifier

29a, Certifier

the Hospitei or Attending Physicien: the within To the comple

Registrar

1 Inpatient 2 FR/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

1 TYes

24b. Were autopsy findings available prior to completion of cause of death?

2 No

Romer attaraseo MD

5 Pending

investigation

6 Could not be determined

D-28097

28c. Injury at Work?

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Name and address of person who completed cause of death (Item 23a) (Type, Print)

2005 Register's Signature

1526 Merret Blod. Suite #14, Balt, Md. 21222

24a. Was an autopsy performe

1 ☐ Yes

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

26. Place of Death (Check only one)

2 No

28d. Describe how injury occurred

			For State Registrar	State of N	Maryland /		rtment of H			ental Hy	giene Reg. No		13	682
			1. Decedent's Name (First, Middle,	Last)						2. Date of D				e of Death
	Physicia /Medic		Betty Ellen	Filling						April	18,	2005		0 P M
	Examin		4a. Facility Name (If not institution,		er)		4b. City, Town, or		of Death	•	4c.	County of De		
			405 H Aggies (				Bel					Harfor	d	
	Funeral		,	5. Sex 7. / 1 ☐ M 2 □ <b>y</b> F	Age (In yrs. last b	virthday) Yrs.	If Under 1 Year Months Days	If Under Hours	Min.	8. Date of B (Month, D July	irth a <i>y, Year)</i>	9. Bi	(Cuntry)	ate or Foreign
	Director		219-12-7523 Usual Residence of Decedent	X.	80	TIS.				July	21, 1	1924 M	arýlav	ıd
	land ow		10a. State 10b. County		10c. City, To	wn or Lo	cation	_					10d. Insid	le City Limits
	Many -feh	ţ	Maryland Harfo	rd.		Ве	l Air						1√	Yes 2 ☐ No
	r 28a	Director	10e. Street and Number				10f. Zip Code				10g. Cit	izen of What C	Country?	
	h witi		405 H Aggies (	Circle			21	1014				U.S.A.		
	deat	Funerai	11. Marital Status	12. Was Deceder Armed Forces	nt Ever in U.S.	13. V	Vas Decedent of Hi f Yes, specify Cubai	spanic Ori	igin? (Spec	cify Yes or N	0-	14. Race - Am Black, Wh		n,
9	or Ita		1 Never Married 2 Marrie				Yes 2X No	Specify:		110411, 010.7			white	
8	ural',	d by	3 Widowed 4 □ Divorced	Year or Dates										
7	within 72 hours after death with the Maryland ene. than "natural", or Itame 23s or 28s-f ehow he Madical Examiter mat be matified at	Completed	15. Decedent's (Specify only highest	grade completed)	16	a. Deced (Give	lent's Usual Occupa kind of work done d DO NOT use retired,	ation <i>luring m</i> os	t of workin	g	16b. K	ind of Busines	s/Industry	
12	withi	mc	Elementary/Secondary (0-12) 12th Grade	College (1-4o	or 5+)		Homemake					Own Ho	me	
0	Hygi other ant,	Be C	17. Father's Name (First, Middle, La	ast)					er's Name	(First, Middle	e, Maiden			
Maryland 21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygiene. If Item 27 is marked other than "natural", or Itame 23s or 28s-f ehow or other traumatic evant, the Modical Examinet mant be notified at	To B	William R	yan				1	da	wil	son			
ary	shot and N s me		19a. Informant's Name/Relationshi	p (Type, Print)	19	b. Mailin	g Address (Street a	and Numbe	er or Rural	Route Num	ber, City o	r Town, State,	Zip Code)	
	and 2 saith a 127 is ar trai		Thomas Filling	(son)		9502	Amberle	igh L	ane,	Unit	E, Per	vry Hal	e, MD	21128
ore	of He of He r oth		20a. Method of Disposition 1 ☐ Burial 2 🂢 Cremation 3	3 □Bemoval from Sta	cemet	ery, cren	sition (Name of natory or other place			ate	B	ocation - City o		
Ĕ	Pag ment ant: f ury o		'4 □ Donation 5 □ Other (Spe		" Bayvi		Crematory					timore,	_	land
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any injury or othar once.		21. Signature of Funeral Service Li				. Name and Addres 705 Belau							
			23a. Part1. Enter the disease, or c shock, or heart failure. List or	omplications that caus	sed the death. Do	not ente	er the mode of dying	g, such as	cardiac or	respiratory	arrest,		Approx Interval	mate Between #
	Physician :	8	Immediate Cause (Final disease or condition			1000	nic Hear	+7	di ser	e			Onset a	und Death
1	/Medical		resulting in death)	Due to (or a	as a consequence				,,,,-					AND DEC. 113
	Examiner		Sequentially list conditions.	b										
	sit s	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usaase or injury that initiated events	Due to (or a	as a consequence	e of):							1	
	and I-tran	Examin	that initiated events resulting in death) Last	c	as a consequence	e of):							-	
8760,	cate be executed physician and the burial-transit					,-								
687	death certificate be executed e attending physician and id for use as the burial-transit	edicai		d										
Box	eath certific attending p for use as	ian/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom			)c.,					23d. Date of de	elivery	
	death e atte id for	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregnant	2 Fetal dear at time of death		Ectopic pregnancy   Other (s <i>pecify)</i>					Month	Day	Year
P.0	t the by th tache	Physicia	9 Unknown	9□ Unknown	1						ļ			
		by P	Part II. Other significant condition	s contributing to death	but not resulting	in the ur	nderlying cause give	n in Part I		23e. Did	tobacco u	use contribute t	to the cause	of death?
ord	w requires been sign should be									1	Yes 2	□ No 3 □ F	robably 4	Onknown
Records,	aw as h	Completed								24a. Wa auto	psy	prior to	completion	ngs available of cause of
<b>E</b>	The ate h page	Соп								perf	ormed? 2.☑No	death?	s 2 No	
Vital	sician: T certificat rector, pa	Be	25. Was case referred to medical examiner?	Manitali			l out		of Death	(Check only	one)			
of	this al di	2	1 Yes 2 No	Hospital:				4 🗀 NU				6 ☐ Other (Spe	ecify)	
n C	ing After une	ion	27. Manner of Death  1 Natural 5 Pending		Day Year)	. Time of Injury	28c. Injury Work			3d. Describe	now injur	у оссиггөа		
isi	ten leat tor: the	icat	2 Accident investigated investigated and accident investigated and according to the could not be accepted as a constant of the could not be accepted as a	ot be as Place of I	Injury - At home,	farm stre		63 21		Rf. Location	(Street an	d Number or F	Bural Route I	Vumber
Division	of or Attendate death I Director:	Certification;	4 ☐ Homicide determin	ed building,	etc. (Specify)	rann, our	oot, radiory, orriod				wn, State			
	To the Hospital or At within 24 hours after of To the Funaral Direct completely filled in by			Physician: To the be										
	n 24 l he Fu pletely	ledical	(Check only 2 Medical E.	xaminer: On the basis and manner	of examination a stated.	and/or inv	estigation, in my op	oinion, dea	th occurre	d at the time	, date and	d place, and du	e to the cau	se(s)
	To the I	Σ	29b. Signature and title of certifier	1) _			29c. License	number				te signed (Mon	* -	
•	2		C Want 1	Firminero	-9		Itoo	544	39		AP	ril 20	, 200	5
1	გ <sup>∪</sup>		30. Name and address of person w		f death (Item 23a	(Туре	Print) Atwood	2	1 # 7	ac "	Ral	ril 20 Air, wi	) 711	14
-	Sta	te.	31. Date filed (Month, Day, Year)	32 Aegis	strar's Signature	·	primes a	100	- 102	-0	- CI	, , ,	210	,
	Registr		31. Date filed (Month, Day, Year) APR 2 2	2005	w &	Abra	WE							

Baltimore, Maryland 21215-0036

P.O. Records. Vital of

Division

that the death certificate be executed Box 68760

Amend Items 24a,25,26,27,29a Department of Health and Montal Hygiene Certificate of Death

Reg. No. 1 - For State Registrar Reg. No. 1 Decedent's Name (First Middle Last) 2 Date of Death Month Year **Physician** Frankland McIntyre Gorham 55 P M 2000 Hori /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4h City Town or Location of Death Examiner GIENBURNIE If Under 1 Year | If Under 24 Hrs. NORTH Arundal 8. Date of Birth Month, Day, Mar 10, 5. Social Security Number Age (In yrs. last birthday, Birthplace (State or Foreign
Country) **Funeral** Days Months Hours Min 1X M 2□F 159-32-4955 Yrs 66 Director Pennsylvania Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a State 10b County 10d. Inside City Limits id 2 should be filed within 72 hours after death with the Marylar th and Mental Hygiene. 27 Is marked other then "naturel", or Items 23a or 28e-f show traumatic event, the Marical Examiner must be notified at 1 ☐ Yes 21 No MD Director Anne Arundel Millersville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 451 Obrecht Road 21108 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 No 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 XMarried 1 ☐ Yes 2 No If Yes, Give Year or Dates: Specify: 3 ☐ Widowed 4 ☐ Divorced white 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) carpenter construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Frank Gorham Edith Hill 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health an item 27 l Joan Gorham/spouse 451 Obrecht Road Millersville, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If it eny injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☑ Donation 5 ☐ Other (Specify) 21. Signature of Euneral Service Roma Ld S. Wade 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 Director 21002 23a. Part . Enter the disease, or complications that can shock, or heart failure. List only one cause on ea caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** MYO CALDIAC ACUTE /Medical Due to (or as a consequence of): Examiner 12ENAC Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and the burial-transit Due to (or as a consequence of): Physician/Medlcal attending p for use as IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes ■ No 24a Wasan X No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner Hospital: Other: 1 ☐ Yes 2 X No 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ၉ this Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After To the Hospitel or Attending 5 Pending investigation 1 Natural
2 Accident Injury death. 2 🗆 No Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) rundel 31. Date filed (Month, Day, Year) 32. Registrar's Signature State APR 2 2 2005 2016 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		,	For State Registrar	State o	f Maryla	-	artment of rtificate of		and M		eg. No U	05	13684
	Physici	an	1. Decedent's Name (First, Middle,	Last)						2. Date of Deat Month	Day	Year	3. Time of Death
	/Media		William		6 - 3	Harvey			(0)	April 4	10,00		1175 AM
}	Examin	er	4a. Fecility Name (If not institution,	-			4b. City, Town	, or Location o timore	of Death		4c. County	of Death	
			Union Memoria  5. Social Security Number			s. last birthday			24 Hrs.	8. Date of Birth		9. Birtho	place (State or Foreign
	Funeral Director		231-36-4993	1,□M 2□F	72		Months Day	s Hours	Min.	8. Date of Birth (Month, Day, Dec 19,	1932	Cour	inia
	ס		Usual Residence of Decedent										
	arylar show		10a. State 10b. County		10c. (	City, Town or L	ocation					1	10d. Inside City Limits 1 1 Yes 2 □ No
	8a-f	Director	MD		Ва	1timore					0. 0.0	1411	
	with the		10e. Street and Number				10f. Zip Code 2121				0g. Citizen of	What Cour	ntry?
	eath is 23	Funeral	700 West 40th S	12. Was Dece	dent Ever in	IIS 13	Was Decedent o		igin? (Sn		USA 14 Bac	e - Americ	can Indian
	fter d	Fun	1 □ Never Married 2 □ Marrie	Armed Fo	rces?	0.0.	If Yes, specify Co	uban, Mexicar	n, Puerto	Rican, etc.)		ck, White,	
93	urs a	by	3 ∑ Widowed 4 □ Divorced	If Yes, Giv Year or D	e		1 ☐ Yes 2X☐ N	lo Specify:			Specif	y: Bla	.ck
2	be filed within 72 hours after death with the Maryland ital Hygiene. Id other than "natural" or Items 23a or 28a-f show other than "natural" or Items 23a or 28a-f show avant, its Medical Examina trunsite it offit of at	Completed	15. Decedent' (Specify only highes			16a. Dece	dent's Usual Occ	upation	t of work	ina	16b. Kind of B	usiness/In	dustry
7	ithin Ban	npie	Elementary/Secondary (0-12)	College (1	-4or 5+)		kind of work dor DO NOT use reti	red)		9			
2	filed within Hygiene. thar than "		17. Father's Name (First, Middle, L	204)		La	borer	10 Moths	arla Mara	e (First, Middle, M	Sawm:		
and	ould be fi Mental H arkad ot atic evar	Be	Jesse Harvey	.451)						Brice	Maideri Surnai	110)	
Maryland 21215-0036	s 1 and 2 should by Health and Ments itam 27 Is merked other traumetic er	2	19a. Informant's Name/Relationsh	in (Type Print)		19b Mail	ing Address (Stre			al Route Number	City or Town	State Zic	Code)
<b>≥</b>	and 2 s salth an n 27 Is iar trau		James Harvey -				Erdman A			ltimore,		1213	. 0010,
	is 1 an of Heal itam 2 othar		20a. Method of Disposition		20b		osition (Name of matory or other p				20c. Location		own, State
E			1 ☑ Burial 2 ☐ Cremation 1 ☐ Donation 5 ☐ Other (Sp		State		Bapt.		4-1	4-05	Madis	onvil	le, VA
Baltimore,	그는 분들		21. Signature of Funeral Service L	Property of the Control of the Contr			2. Name and Add	dress of Facilit	ty	1 11			, , , , ,
œ	Depar Impo any it		July 1	1900	do	20	Bland-R. P.O. Box	eid Fui x 325	nera Farm	1 Home ville. V	A 239	01	
	Physician /Medical Examiner	J.	234 Part 1 Enter the disease or shock, or heart failure. List of immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate	aDue to (	ach line.	equence of):	vyhy Teart	tying, such as Hhmid U	cardiac U Seu	or respiratory arre	est,		Approximate Interval Between Conset and Death
9,0928	The law requires that the death certificate be executed at the bean signed by the attending physician and bage 2 should be detached for use as the burial-transit	edical Examiner	ically, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	с	or as a cons	,							
.O. Box 6	at the death certific by the attending p tached for use as i	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		irth 2 ☐ Fe ant at time o	etal death 3	□Ectopic pregnar □ Other (specify)					ate of deliver	ery Day Year
rds, P	w requires that been signed k should be det	by	Part II. Other significant condition	_	eath but not r	esulting in the	underlying cause	given in Part I		23e. Did tot	_	tribute to th	he cause of death?
Records,	The law re ate has bee page 2 sho	Completed	Olabetes	Mellita	5					24a. Was a autops perform	ned?	Were autoprior to codeath?	ppsy findings available impletion of cause of
Vital		BeC	25. Was case referred to medical examiner?					26. Place	of Deat	h (Check only on			~
of V	Physicia this cer al direct	2	1 ☐ Yes 2 No	Hospital: 1 □ 1	npatient 2	XER/Outpatie	nt 3 DOA		ursing Ho	me 5 🗆 Reside	ence 6 Oth	ner (Specif	5)
sion o	ing f	ation:	27. Manner of Death  1 Astural 5 Pending investig	ation	of Injury th, Day Year)	28b. Time ( Injury	V	ljury at Vork? Yes 2	No	28d. Describe ho	ow injury occur	red	
Division	tal or Attand rs after death al Director: ed in by the f	Certification;	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determi	ned 200. Place	of Injury - At ng, etc. (Spe		treet, factory, offic	ce .		28f. Location (St City or Town		ber or Rura	al Route Number,
	To the Hospital or within 24 hours after To the Funeral Director Completely filled in Director Completely filled in Director Completely filled in Director Completely filled in Director Completely filled in Director Completely filled in Director Completely filled in Director Completely filled in Director Completely filled in Director Completely filled in Director Completely filled in Director Completely filled in Director Completely filled in Director Completely Complet	Medical		g Physician: To the Examiner: On the b and man						red at the time, d	ate and place,	and due to	o the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \			29c. Lice	nse number	41	02 2	9d. Date signe	d (Month,	Day, Year)
•			William	thron	RAMO		N	0 02	11	03	TIPY1/	12,	2005
	3		30. Name and a dress of pers in	Frohna	, Un	ion Me	MeVial	Hapita	1,0	201 E. U	nNewix	Par	Kury,
	Sta Regist		31. Date filed (Month, Day, Year)  APR 2. 2. 200	41	egistrar's Sig	gnature	· O	•	J		V	Dalt	morthodia

		1 - For State Registrar		f Marylan		artment of H rtificate of I			R	eg. No.		13685
Physicia	an	Decedent's Name (First, Mid	dle, Last)						<ol><li>Date of Dea Month</li></ol>	h Day	Year	3. Time of Death
/Medic	_	Jane Beale	Herndon						April 1	7		10:45 AM
Examin	er	4a. Facility Name (If not institut				4b. City, Town, or	r Location of	of Death		4c. County		
		2500 Waterside 5. Social Security Number		t. 202 7. Age (In yrs.	last hirthday	Frederic	ck If Under	24 Hrs	9 Date of Birth	Frede		Naco (Chata au Familia)
Funeral Director		226-42-7788	1 M 2 M F	7. Age (iii yis. 93	Yrs.	Months Days	Hours	Min.	8. Date of Birth (Month, Day May 30	Year) 1 9 1 1	Cour	place (State or Foreign ntry) Sinia
		Usual Residence of Decedent							nay 50	, 1)11	VILE	STILLE
yland Now		10a. State 10b. Cour	ity	10c. Cit	y, Town or Lo	ocation					1	0d. Inside City Limits
Mar Hied	ţċ	MD Fred	lerick	Fr	ederio	ck						1 ☐ Yes 2 📉 No
17 the	ire	10e. Street and Number				10f. Zip Code			1	0g. Citizen of	What Cour	ntry?
15 wi	Funeral Director	2500 Waterside	Prive #20	2		2170	1			USA		
ems ems	ine	11. Marital Status	12. Was Dece Armed For	edent Ever in U	.S. 13.	Was Decedent of Hill Yes, specify Cuba	ispanic Ori	igin? (Spe	ecify Yes or No- Rican, etc.)		ce - Americ ck, White,	
or It		1 Never Married 2 M	If Yes, Giv	/e 41		1 ☐ Yes 2 ☑ No	Specify:			Specif	v-	
filed within 72 hours after death with the Maryland Hygiene Hydiene Hydiene 1990 or 289-1 show ther than "natural", or items 239 or 289-1 show ant, the Medical Examinar must be notified at	d by	3 X Widowed 4 □ Divorc		ates:	100 0000	danda Harri Orari	_4:				Wr	nite
n 72 nat	Completed	(Specify only high	ent's Education hest grade completed)		(Give	dent's Usual Occupa kind of work done of DO NOT use retired	durina mos	st of worki	ng	16b. Kind of B	usiness/in	dustry
withii ene.	ᇤ	Elementary/Secondary (0-12	College (1	l-4or 5+)		acher	•/			Educ	atior	1
filed Hygi Hygi Sther ent, I	ပိ	17. Father's Name (First, Middle	<u> </u>				18. Mothe	er's Name	(First, Middle,		*	
d be sontal	œ o	Edwin J. Beale	2				Ι	na R	ogers			
shoul nd M marl	-	19a. Informant's Name/Relatio	nship (Type, Print)		19b. Maili	ng Address (Street a				, City or Town,	State, Zip	Code)
nd 2 lith a 27 is r trat		Edwin Beale He	erndon - So	n	2500	Watersid	le Dr	. #20	)2 Frede	rick,	MD 2	1701
f Hear f Hear ltem othe		20a. Method of Disposition			Place of Dispo	osition (Name of matory or other place	ا (م		ate	20c. Location	- City or To	own, State
Page ento nt: If ry or		1 ☑ Burial 2 ☐ Crematio 1 ☐ Donation 5 ☐ Other		State i		l's Episco	· 1	4-1	15-05	Woodvi	11e,	VA
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Menial Hydiene. Inmportant: If time 27 is marked other than *natural; or items 28 or 28e-1 show any injury or other traumatic event, the Medical Examena must be notified at once.		21. Signature of Funeral Servi				2. Name and Addres Clore Ei		ξ r	nomal U	> ***		
Departing Department of the concernation of th		aren.	6 arros	Q Q V		11190 J					ar 1	7 Δ
	1	23a. Parl 1. Inter the dise ock, or heart failure.	or complications that c	aused the deat	h. Do not ent		431133445544					Approximate Interval Between
Physician	-	Immediate Cause (Final	-	imer's	Damant	od a						Onset and Death
/Medical		disease or condition resulting in death)		oras a conseq		та					m	onths/vears
Examiner												
SERVE	je	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Ulsease or Injury)	Due to (	or as a conseq	juence of):							
cuted nd ransi	Examiner	that initiated events	С.									
an ar	EX	resulting in death) Last	Due to (	or as a conseq	uence of):							
certificate be executed adding physician and use as the burial-transit	Physician/Medical		d.									
leath certifica attending ph	Med	IF FEMALE:										
death ce	an/	23b. Was decedent pregnant in the past 12 months?		oirth 2 Feta	ıldeath 3 [	Ectopic pregnancy	,				ite of delive onth	ery Day Year
e de the a	Sic	1 ☐ Yes 2 No 9 ☐ Unknown	4☐Pregn 9☐Unkno	ant at time of down	leath 5	Other (specify)						
res that the de signed by the a be detached t	Ph	Part II. Other significant cond	itions contributing to de	eath hut not rec	ulting in the u	ndorhina cauca and	on in Part I		23e Did to	acco use con	tribute to th	ne cause of death?
resti signe f be c	þ	Tatti. Stror significant cond	moris commoduling to de	5411 541 101 193	diting in the b	riderlying cause give	oir air i air i	1.		es 2 🗆 No		ably 4 Unknown
law requires that the as been signed by th 2 should be detache	Completed								STATE OF THE PARTY		eminary posterior	
elaw hast je2s	npl du								24a. Was a autops perfor	y	Were auto prior to co death?	psy findings available mpletion of cause of
ate ate	Ö											2 No
Physician: Th this certificate ral director, pag	Be	25. Was case referred to medi examiner?	Hospital:			Oth			(Check only or			5-E-1
hys his	2	1 Yes 2 No 27. Manner of Death	28a. Date of		ER/Outpatier 28b. Time o				me 5 Reside			y)
ding After funer	lon	1 Xatural 5 ☐ Pen		th, Day Year)	Injury	Worl	k? Yes 2.⊡		ECG. Describe in	W Injury occur	100	
death death ctor: / the	ica	3 Suicide 6 □Cou	ld not be	of Injury - At h	ome farm str	reet, factory, office		-	28f. Location (S	reet and Numb	oer or Rura	I Route Number.
after Dire	Certification:	4  Homicide dete		ng, etc. (Specif					City or Town			
To the Hospitel or Attending P within 24 hours after death. To the Funeral Director: After t completely filled in by the funeral		29a. Certifier 1 XCertif	ying Physician: To the	best of my kno	wledge, deat	h occurred at the tin	ne, date ar	nd place, a	and due to the c	ause(s) and ma	anner as s	tated.
e Full letely	edical	(Check only 2 Medic one)	al Examiner: On the ba	asis of examina ner stated.	ition and/or in	vestigation, in my of	pinion, dea	ath occurre	ed at the time, d	ate and place,	and due to	the cause(s)
To the within 2 To the complet	Me	29b. Signature and title of cert	11/10	-		29c. License	e number		2	9d. Date signe	d (Month,	Day, Year)
		) K	Well			D 264	499			April :	12. 2	005
10		30. Name and address of pers	on who completed caus	se of death (Iter	n 23a) (Type,					TTTT.	- L 9 L	
10		Ronald E. Mill	er, M.D.	4 Culw	ell Dr	ive, P.O.	Вох	210.	Mt. Ai	ry. MD	2177	1
<sub>*</sub> Sta	ite	31. Date filed (Month, Day, Ye	ar) 22. R	legistrar's Signa	ature 🦽							
Registr	ar	APR 2 2	2005	ms A	A Second							

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760, <

		•	1 - For Amend item#	State PII,28b,28d	of Mar perME	yland / Depa ,8861,11 <i>/</i> 0/0	artment of H	lealth and I Death	Mental Hy	giene Reg. No.	- Commander	10000
		40	1. Decedent's Name (First, Mid						2. Date of De		Year	3. Time of Death
	Physicia /Medic		Anne C Hea	ley					A.M.C.	16	2005	12:35 P M
	Examin		4a. Facility Name (If not institut	ion, give street and	number)			Location of Death	h	4c. County of		
			Frederick				Frede:		9 Date of Bir	Frede		on /State or Foreign
	Funeral Director		5. Social Security Number 142–14–2937	6. Sex 1 ☐ M 2X☐ F		(In yrs. last birthday) 91 Yrs.	Months Days	Hours Min.		24, 1913	New .	ce (State or Foreign y) Jersey
	pue M		Usual Residence of Decedent 10a. State 10b. Cour	nty	1	IOc. City, Town or Lo	cation				100	d. Inside City Limits
	Manyl f sho	ō	MD Fred	erick		Frederio	ck					1 ☐ Yes 2 No
	28a	Director	10e. Street and Number				10f. Zip Code			10g. Citizen of W	/hat Countr	y?
	h with	O E	5955 Quinn Or	chard Roa	d		21704			USA		
96	I within 72 hours after death with the Marylend liene. r than "natural", or Items 23a or 28a-f ehow the Medical Examirat must be molified at	by Funeral	11. Marital Status  1 □ Never Married 2 □ N	Armed arried 1 ☐ Ye	ecedent Ev Forces? s 2 → No Give X		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ※ No	ispanic Origin? (S in, Mexican, Puert Specify:	pecify Yes or No to Rican, etc.)		- America k, White, et	c.
8	ural,		3 X Widowed 4 □ Divord	ed Year o	r Dates:	160 Dagg	dent's Usual Occup	ation		16b. Kind of Bu		ite
21215-0036	n 72	Completed	(Specify only hig	hest grade complete		(Give	kind of work done of DO NOT use retired	during most of wor f)	rking	TOD. KING OF BUS	3111053711100	istry
12	within isone.	mo	Elementary/Secondary (0-12	2) Colleg	e (1-4or 5+)	Homer	naker			Own I	Home	
	filed Hyg othe	60	17. Father's Name (First, Midd	le, Last)				18. Mother's Nan	me (First, Middle	, Maiden Sumame	e)	
lan		To B	Thomas Carey					Sadie H	avillano	d		
Maryland	d 2 should th and Men 7 Is marke treumatic		19a. Informant's Name/Relation	enship (Type, Print)		19b. Mailii	ng Address (Street	and Number or Ru	ural Route Numb	oer, City or Town,	State, Zip (	Code)
	5 <del>5</del> % L		Thomas C. Hea	ley (Son)			5 Aspen D					
ore	0 to to to		20a. Method of Disposition  1 ★ Burial 2 □ Crematic	n 3 □Removal fro	om State	20b. Place of Dispo cemetery, crea			Date	20c. Location - (	City or Tow	n, State
Ē	Pag ent ent ry o		4 □ Donation 5 □ Other		on Otato	Holy Cros		1	1-05	North A	rling	ton, NJ
Baltimore,	pernit. Pag Department Importent: any injury once.		21. Signature o Funeral Servi	ce Licensee	140		Name and Addre	ss of Facility neral Ho	me	4	- N	
	70 = 8 Q	/	23a. Part1. Enter the disease		SUS		684 Kearn				35 <b>3</b> 6	Approximate
			shock, or heart failure. I	ist only one cause of	n each line					27	11 321	nterval Between Onset and Death
,8760,	The law requires that the death certificate be executed as the law requires that the attending physician and page 2 should be detached for use as the burial-transit	dical Examiner	resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b	to (or as a	consequence of):	brilla tenosi			of of the	not co	yers years
O. Box 6	at the death certific by the attending partached for use as f	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 □ Lit 4 □ Pr	e birth 2		□Ectopic pregnancy □ Other (specify) _	,		23d. Date Mor	e of deliver	y Day Year
ds, P.	ires that signed t d be det	by	Part II. Other significant cond	ditions contributing t	o death but	not resulting in the u	inderlying cause giv	en in Part I.		tobacco use contr	ribute to the 3	
Records,	w require been sign	Completed	Encort	1- 41	' (	2 P.11	,		24a. Wa:	s an 24b. V	Vere autop:	sy findings available
Re	he law e has ige 2 s	dmo	Enceph	ropath	y <del>17</del>	om regi			auto	opsy p ormed? d	rior to com leath?	pletion of cause of
Vital	iffication, pe		Head injury 25. Was case referred to med	icat				26. Place of Dea	1 ☐ Yes ath (Check only		105 2	140
>	Physician: this certificated ral director, I	To Be	examiner? 1 XYes 2 □ No	Hospital:	Inpatien	t 2 ER/Outpatie	nt 3 DOA Oth	00		sidence 6 Othe	er (Specify)	
J of	ng Ph ter th neral		27. Manner of Death 1 □Natural 5 □ Per	//	ate of Injury Month, Day	Year) 28b. Time o	of 28c. Injur Wor	y at k?	28d. Describe	how injury occurred Subject	fell.	
Division	ottendir death. ctor: Al y the fu	Certification:	2 Accident inve	estigation 4-	13-0	5 516		Yes 2 No	tell	in B	athi	0000
≅	br Att fter di irect n by 1	riii		ermined 28e. P	ace of Injur uilding, etc.	y - At home, farm, st (Specify)			28f. Location City or To	(Street and Number own, State) 5 9	5.5 Qu	rinn Orchardk
	urs al			t in Observation To	also been ad		home		Frede	rick Mi		704
	Hos 24 ho Fundately f	Medical		cal Examiner: On th		my knowledge, deat examination and/or in ed.						
	To the Hospitel or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Me	29b. Signature and title of cer	tifjer \			29c. Licens			29d. Date signed	4.2	
	FSFO	İ	) Jan	& Con	s Que	2	23	58877	_	4/19	102	
	20		30. Name and address of per	son who completed	ause of de	ath (Item 23a) (Type	Print) 9093 (	2 ^ (			1100	Flocence
	U		Jakel C	- iarleon	us k	- mb	90931	Lidget	red 10	1100 30	4710	
<b>.</b>		ate	31. Date filed (Month, Day, Yo	ear) 3	2. Registra	's Signature	0200					21701
	Regist		APR 2 2	2005	100	H Sign	Also de la constantina della c					
U)	HMH 17 Rev 1/2	2001		4		ORIGIN	AL					

			For State	State of Ma	aryland /		artment of H			201	7 [	10007
			Registrar  1. Decedent's Name (First, Middle, La	st)		Cel	lilicale of L	Dealli	2. Date of De	Reg. No. U	JJ	3. Time of Death
	Physici /Medio		Marleny		Hena	0 -	- Alar	con	Month	18	O-5	8 A M
	Examir		4a. Facility Name (If not institution, giv	e street and number)				Location of Deat	า	4c. Count	y of Death	
	Funeral		430 West Court 5. Social Security Number 6. S	ex 7. Aq	je (In yrs. last	birthday)	If Under 1 Year	Burnie If Under 24 Hrs.	8. Date of Bir		e Aru	ndel
	Funeral Director			□M 2⊠F	66	Yrs.	Months Days	Hours Min.	(Month, Da	aÿ, Year) 13–1938	Cour	place (State or Foreign of try) Olumbia
	and w.		Usual Residence of Decedent  10a. State 10b. County		10c. City, To	own or Lo	cation					0d. Inside City Limits
	Maryl Fied a	ţō	Maryland Anne A	rundel			G1en	Burnie				1 ☐ Yes 2 ☑ No
	or 28c	Director	10e. Street and Number				10f. Zip Code			10g. Citizen of	What Cour	ntry?
	s 23a	ral	430 West Court	10 14- 0	E TO US	10.1		21061			umbia	
(0	ours after death with the Marylan rel', or Items 23a or 28e-f show Examiner must be notified at	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑			Was Decedent of Hi f Yes, specify Cuba			Bla	ce - Americ ick, White,	
003	72 hours after death with the Maryland "neturel", or Items 23a or 28e-1 show disal Examiner must be notified at	d by	3 X Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:			1 X Yes 2 □ No	Specify: Col	umbian	Speci	<sup>fy:</sup> Wh	ite
15-(	n 72 h	lete	15. Decedent's Education (Specify only highest graduations)		16	Ga. Deced (Give	ient's Usual Occupa kind of work done of DO NOT use retired	ation during most of wor	king	16b. Kind of E	Business/In	dustry
212	filed within Hygiene. Ither than "	Completed by	Elementary/Secondary (0-12)	College (1-4or 6	5+)		omemaker	,		Но	useho	ld
pu	be filed stal Hygi od other event, I	Be	17. Father's Name (First, Middle, Last,					18. Mother's Nan		, Maiden Suma	me)	
Maryland 21215-0036	2 should be filed and Mental Hygi Is marked other aumatic event, II	ဥ	Marco Tulio  19a. Informant's Name/Relationship (	Henao	10	Ob Mailir	ig Address (Street a	Clemen		Alarcon	State 7in	Codel
	alth ar 27 is		Marlen B. Marsh-H		hter)		Cork Elm					0000)
Baltimore,	ges 1 and 2 should be filed within 72 hc t of Health and Mental Hygiene. If item 27 is marked other than "netur or other traumatic event, The Medical		20a. Method of Disposition 1 ☐ Burial 2 🏋 Cremation 3 ☐	Removal from State	20b. Place ceme	of Disno	sition (Name of natory or other place			20c. Location		own, State
tim	Ly Single Pa		* 4 ☐ Donation 5 ☐ Other (Specif 21. Signature of Funeral Service Lice	<sup>(1)</sup>	Metro	Cre	matory Ir	nc.   2	005	Baltim	ore,	Maryland
Ba	permit. Departr Importe any inju		21. Signature difference also allocations	21/1		22	. Name and Addres		Stalling ad Pasa	gs Funer	al Ho	ome, P.A.
			23a. Part1. Enter the disease, or comshock, or heart failure. List only	plications that caused one cause on each li	the death. D	o not ent					10 21	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	0	ocars	)	1 into	retio	n		1	onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a consequence	e of):	tuca	1. 100	culon	2	0.	10000
	,	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as	a consequence	9/0 e of):	11C (Or	CIUYCO	CUICK	Cosea	7.6	419115
V	ecuted and transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c								
8760,	The law requires that the death certificate be executed the has been signed by the attending physician and age 2 should be detached for use as the buriat-transit		, southing in country cust	Due to (or as	a consequenc	e or):						
9	ifficate I g physi as the t	ledical		d								
Вох	leath certific attending pl	an/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth		ıth 3□	Ectopic pregnancy				ite of delive	*
.O.	at the dea by the at tached fo	Physician/Med	1 Yes 2 No	4□Pregnant at 9□Unknown	time of death		Other (specify)			Mi	onth	Day Year
<b>a</b>	s that t ned by e detac	by Ph	Part II. Other significant conditions	ontributing to death b	ut not resulting	in the u	nderlying cause give	en in Part I.	23e. Did to	obacco use con	tribute to th	ne cause of death?
Vital Records,	w requires been sign should be		merostati	c 9'05	SIMIC	('(	ancer		101	Yes 2 No	3 ☐ Prob	ably 4 □Unknown
Seco	e law r has be je 2 sh	Completed							24a. Was autop	osy	prior to cor	psy findings available inpletion of cause of
alF		e Col	25. Was case referred to medical					00 Bt	1 ☐ Yes	2 <b>P</b> No	death? 1 🗆 Yes	2 No
f Vii	S S	To B	examiner? 1 Yes 2 No	Hospital:	ent 2 ER/0	Dutpatien	t 3 DOA Othe	26. Place of Dea er: 4 ☐ Nursing H		one) dence 6 □Ott	ner (Specif	/)
n of			27. Manner of Death 1 ■Natural 5 □ Pending	28a. Date of Inju (Month, Da	ry 28b	. Time of Injury	28c. Injury Work		28d. Describe t	how injury occur	red	
Division	eat or:	ficat	2 Accident investigation 3 Suicide 6 Could not b		urv - At home.	farm, str	M 1 1	Yes 2 DNo	28f. Location (5	Street and Numi	oer or Rura	I Route Number,
Οį	dospitel or Att thours after d unerel Direct ely filled in by i	Certification:	4  Homicide	building, et	c. (Specify)				City or Tov	wn, State)		
	2 - 10	edical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exar	ysician: To the best niner: On the basis of and manner sta	f examination a	ge, death and/or inv	occurred at the time restigation, in my op	ne, date and place pinion, death occu	, and due to the rred at the time,	cause(s) and m date and place,	anner as st and due to	ated. the cause(s)
	To the Hos within 24 h To the Fur completely	Me	29b. Signature and title of certifier	1/ /=			29c. License	number		29d. Date signe	d (Month,	Day, Year)
	1		) AC	1) GPC	wn	3	Da	5611		4-18	-05	
	4		30. Name and address of person who Tra E Kaplan	completed cause of d	eath (Item 23a	(Type,	+300 Gle	en Rum	IR Mo	אוחוב ל	.1	
	Sta		31. Date filed (Month, Day, Year)	32. Segistr	ar's Signature	1	antes	on our	101.10	· 0100	1	- =
	Registr	ar	APR 2 2 2	LUUD JOHN	w st	19						

			For State Registrar	State of Mary		artment of I			giene	05	13688
Z.	Physici /Medic		1. Decedent's Name (First, Middle,	Last) L Hatch	het			2. Date of De. Month	2O	2005	3. Time of Death (603 M
	Examir Funeral Director	er	4a. Facility Name (If not institution,  Northwest    5. Social Security Number    264 - 13 - 5300	tospital Co	ntor 1 yrs. last birthday, 50 Yrs.	4	If Under 24 Hrs. Hours Min.	$\sim$	Ba	9. Birthpla Countr	MC ace (State or Foreign y) In ida
100	D	Director	Usual Residence of Decedent  10a. State 10b. County  Maryland Bal		c. City, Town or L	ı/a				100	d. Inside City Limits 1 ∐Yes 2 X No
9	n 72 hours after death with the Maryland "natural", or Items 23a or 28a-f show coloul Esacities must be rollited at	Funerai	2 Willowbrook  1. Marital Status  1 Never Married 2 Marrie	12. Was Decedent Eve Armed Forces? d 1 □Yes 2 ☑No	r in U.S. 13.	Vas Decedent of H	dispanic Origin? (S an, Mexican, Puert		- 14. R	USA ace - Americal lack, White, et	n Indian, tc.
Maryland 21215-0036	be filed within 72 hours ital Hygiene. Id other than "natural", event, the Medical Era	Completed by	3 ☐ Widowed 4 ☒ Divorced  15. Decedent's (Specify only highest Elementary/Secondary (0-12)		(Give	dent's Usual Occup be kind of work done DO NOT use retire	pation during most of wor	king	16b. Kind of	Business/Indu Faith	ustry
yland	ould be file Mental Hy, warked other	To Be C	17. Father's Name (First, Middle, La James Hatche	t			Delor	ne (First, Middle, es Prin	nous		
Baltimore,	permit. Pages 1 and 2 should Department of Health and Mer Importent: If tiem 27 is marke any injury or other treumatic <u>once</u> .		19a. Informant's Name/Relationship  DeNika Hatche  20a. Method of Disposition  1 & Burial 2 Cremation 3  4 Donation 5 Other (Special Section 2)  21. Signature Funeral Section 3  23a. Perit 1. Enter the disease, or of shock, or heart failure. List of Immediate Cause (Final	t/Daughter  B   Removal from State acify)  consequence of the caused the chiy one codes on each line.	2 W 20b. Place of Dispresentery, cre King Me	emorial  Name and Addre  To Co  ndallst  ter the mode of dyi	OOK COU Park 4- ess of Facility W y 9200 OWN 21 ng, such as cardiac	rt, Rai 27-05 lie Fur 133 or respiratory an	ndalls 20c. Locatio Randa neral y ku;	stown, n-City or Tow allsto Home	Md 2113; m, State wn, Md
8760,	Physician /Medical Examiner   bubsician and bubsician and sthe pnual-transit   the pnual-transit	icai Examiner	disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a co	onsequence of):	tc Con	nary A	reny	Pice	HSE.	
P.O. Box 68	he death certifi the attending thed for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	Ectopic pregnanc Other (specify)	/			Date of delivery Month D	/ Day Year
	w requires that the bear signed by should be detact	þ	Part II. Other significant condition To Sulin -de	spondent ]							cause of death?
al Reco		Completed	RENAL FIAI	LVRE				1 ☐ Yes	osy rmed? 2.2 No	prior to comp death?	sy findings available pletion of cause of
Division of Vital Records,	ling Phys	ation: To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending investiga	28a. Date of Injury (Month, Day Ye	2 Z ER/Outpatie 28b. Time o Injury	of 28c. Inju- Wo	er: 4 ☐ Nursing H	ith (Check only of lome 5 Residence 128d. Describe h	dence 6 🗆 C		
Divis	F Gire	Certification:	3 Suicide 6 Could no determin		At home, farm, st Specify)	reet, factory, office		28f. Location (S City or Tox		mber or Rural i	Route Number,
	To the Hospitel within 24 hours a To the Funerel I completely filled	Medical	29a. Certifier 1 Certifying (Check only one)	Physician: To the best of m xaminer: On the basis of exa and manner stated	amination and/or in	th occurred at the travestigation, in my o	me, date and place ppinion, death occu	, and due to the irred at the time,	cause(s) and date and place	manner as state, and due to t	ed. he cause(s)
)	To the within 2 To the complet	2	29b. Signature and title of certifier  M. Caute		_	29c. Licens	SSY41		April	ned (Month, Di	ay, Year)
	10		30. Name and address of person w M.CATTER, M	5409 Dla	(Item 23a) (Typ.	Prior	55441 Rardali	stown,	MD	21133	d
7	Sta Regist		31. Date filed (Month, Par Y2r)2	ZUUU 3 A TOMATA'S	Signature "						

			1 - For State Registrar		State o	f Maryla	and / Dep <i>Ce</i>	artmen rtificat					Reg. N	2000	1361	30
	Physici /Medic	cal	Decedent's Name (First, Middentification)     DoAnn Hardest     Aa. Facility Name (If not institution)	У	treet and nu	mber)		4h City	Town or	r Location o	of Death	2. Date of De Month April	19,	2005  c. County of Dear	3. Time of Dea	M
	Examin	ıęr	419 Underwood		ireet and nor	11001)		40. Oity,		Bel A				arford	III.	
	Funeral		5. Social Security Number	6. Sex	1	7. Age (In yı	rs. last birthday	) If Under Months		If Under Hours		8. Date of Bi (Month, D	rth	9 Bid	hplace (State or For	- eign
	Director		216-72-2965	1 🗆	M 204	48	Yrs.	Mortars	Days	Hours	WIII.	07/27			ountry)	
	and and		Usual Residence of Decedent 10a. State 10b. Count	у		10c.	City, Town or L	ocation				10			10d. Inside City Lir	nits
	Maryl	Ď	MD Harf	ord											1 ☐ Yes 2 🗟	
	I 2 should be filed within 72 hours after death with the Maryland n and Mental Hygiene. I is marked other than "netural", or items 23e or 28e-f ehow reumatic event, the Medical Erana ret must be rediffed at	Director	10e. Street and Number	oru		De	el Air	10f. Zip	Code				10g. C	Citizen of What Co	untry?	_
	23a o	a D	419 Underwood	Lane				210	14				Un.	ited Sta	tes	
	r dea	Funeral	11. Marital Status	1	2. Was Dece Armed Fo	edent Ever in	U.S. 13.	Was Dece	dent of H	ispanic Ori an, Mexican	igin? (Spe	cify Yes or N	0-	14. Race - Ame Black, Whit		
20	s afte	by Fu	1 ☐ Never Married 2 ☐ Ma 3 ☐ Widowed 4 ☐ Divorce		1 ☐ Yes If Yes, Giv	/0		1 🗆 Yes	2ENO	Specify:				Specify:	-,	
2-003e	turat	ed b	15. Decede		Year or D	ates:	16a. Dece	edent's Usua	al Occun	ation			16h	Kind of Business	Industry	
<u>ი</u>	nin 72 nin "nin	plet	(Specify only high: Elementary/Secondary (0-12)	est grade	completed) College (1	I-40r 5+)	(Give	e kind of wo DO NOT u	rk done d	durina mos	t of workir	ng		n Home	madati y	
7	od with	Completed	11		College (		Home	maker								
ana	oe file tal Hy d oth	Be (	17. Father's Name (First, Middle	, Last)						18. Mothe	er's Name	(First, Middle	, Maide	en Sumame)		
<u>8</u>	Men	ç	Eugene Anthony		-					Marv		Rent				
			19a. Informant's Name/Relation	, , ,,	. ,									or Town, State, 2	Zip Code)	
a)	s 1 and 2 should f Health and Men item 27 is marke other treumatic		Ronald Hardesty  20a. Method of Disposition	//Hu	sbana_	20b	Place of Disn	osition (Nar	n <i>e</i> of			Air,	T	21014 Location - City or	Town State	
Бант	permit. Pages 1 and Department of Healt Important: If Item 2 any injury or other once.		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (		emoval from		cemetery, cre					pr 22				
	nit. F vartme ortar injur		21. Signature of Funeral Service		0		hesapea	i <b>Ke Cr</b> 2. Name ar				2005	Бел	csville,	Maryland	
ă	Depariment of the part of the		Hu Hu	the	-	MAGGR						l Alter		ives timore, M		
,	Physician /Medical		23a. Part1. Enter the disease, of shock, or heart failure. List immediate Cause (Final disease or condition resulting in death)	or complic st only on	e cause on e	e Eas	static	nter the mod	e of dyin	g, such as	cardiac o	r respiratory a	arrest,	uncer	Approximate Interval Between Onset and Death	1
	Examiner	ï			Due to	(or as a cons	equence or):									
	uted d	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	<b>{</b>	Due to	(or as a cons	equence of):									
8/00,	icate be executed physician and s the burial-transit	dical Exa	resulting in death) Last	L d.	Due to	(or as a cons	equence of):									
O. Box 6	ath certif attending for use a	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 D No 9 ☐ Unknown	23	1 Live b	tcome of preg pirth 2 Fe pant at time o	etal death 3	□Ectopic pi □ Other (sp		,				23d. Date of del Month	ivery Day Year	
cords, P.	w requires that the de been signed by the should be detached	by	Part II. Other significant condit	ions con	tributing to de	eath but not r	esulting in the	underlying o	ause give	en in Part J					the cause of death	
ဂ ဂ	s bee	ompleted										24a. Was		24b. Were au	topsy findings avail	able
Ů L	The law cate has b page 2 st	Ho										auto perf	opsy ormed?	death?	completion of cause 2  No	of
		BeC	25. Was case referred to medic	al						26. Place	of Death	(Check only		10 103	2 110	
_	S S	To	examiner? 1 Yes 2 No	H	ospital:	Inpatient 2	☐ ER/Outpatie	nt 3 DC	Oth	er: 4□Nu	rsing Hon	ne 5 PAes	idence	6 ☐Other (Spe	cify)	
DIVISION O	ending Ph sath. or: After th he funeral	atlon;	Z 🔲 / tooldorit	tigation	28a. Date (Mon	of Injury th, Day Year)	28b. Time ( Injury	of 2	8c. Injury Work	y at k? Yes 2 🗍	2	8d. Describe				
	To the Hospitel or Attending Ph within Z4 hours after death. To the Funerel Director: After th completely filled in by the funeral	Certification;	4   Hornicide	mined	buildi	ng, etc. (Spe						City or To	wn, Sta	ite)	iral Route Number,	
	the Hosp in 24 hou the Fune inpletely fil	Medical	(Check only 2 Medica one)	i Examin	er: On the b	best of my k asis of exami ner stated.	inowledge, dea ination and/or ii	nvestigation	, in my o	pinion, dea	nd place, a th occurre	and due to the	, date a	s) and manner as nd place, and due	to the cause(s)	
0	5 W 5 0	M	30. Name and address of perso		· 	m.	D.			53°	90			pate signed (Month		
0	V							Print)	RO	ad *	+200	O,Be	ei A	ir, MD	21014	
	Sta	ate -	31. Date filed (Month, Day, Yea		- 1 37 R	legistrar's Sig	manure /	and I								

			1 - For State Unpe	end Item 2	State of Magarity, State of Magarity, 3a, pt.II,	aryland / [ 27 per i	Depar <b>me</b> Certi	tment of t 843 ificate of	lealth and i 3-05 tas Death	Mental Hyg R	iene <sub>eg. No.</sub> 0 (	15	13690
	Physici /Medio		Decedent's Name	(First, Middle, Last, Timoth	y James 1	Higgins				2. Date of Dear Month APRIL	Day	Year 005	3. Time of Death 6:54a
	Examin			not institution, give N PARKWAY				4b. City, Town, o	or Location of Death NES	h	4c. County WORCES		
ē	Funeral Director		5. Social Security N 218-54-22	293 1 <sup>1</sup>	7. Ag	e (In yrs. last bir 46		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of 8 irth (Month, Day) July 8	1958	9. 8irthp Coun Mary	lace (State or Foreign try) Land
)	land ow		Usual Residence of 10a. State	10b. County		10c. City, Tow	n or Loca	ition				1	0d. Inside City Limits
	a-fsh	ctor	Md.	Worcester	•	Ocea	an Pi	.nes					1 ☐ Yes 2 ☐ No
	h with the 23a or 28	Funeral Director	10e. Street and Nun	nber L80 Ocean	Parkway			10f. Zip Code 218	11	1	0g. Citizen of W	hat Cour	
920	72 hours atter death with the Maryland natural', or items 23a or 28a-1 show dicel Examinat must be rodified at	by	11. Marital Status 1  Never Marri 3  Widowed	ed 2 Married 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 2 A If Yes, Give Year or Dates:	Ever in U.S.		as Decedent of H res, specify Cub	dispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	8 laci	Amend k, White, Whi	
215-0036	n 72 ho natur	Completed		15. Decedent's Edu ify only highest grad	e completed)		. Deceder (Give ki	nt's Usual Occup nd of work done O NOT use retire	oation during most of wor d)	rking	16b. Kind of Bu	siness/Ind	dustry
2	ed withi	Comp	Elementary/Second 12	2	College (1-4or :	5+)		scaper			Landso	apin	g
Maryland	d be file antal Hy sed oth c avant	Be	17. Father's Name (	(First, Middle, Last) nes R. Hig	rgins					ne <i>(First, Middle, I</i> arbara Po		9)	
ary	should nd Me mark umatic	To		me/Relationship (Ty		19b	. Mailing	Address (Street	and Number or Ru			State, Zip	Code)
	and 2		Debra Ar	nn Higgins	- Wife	11	.80 C	cean Pa	rkway, Oc	cean Pine	s, Md.	2181	1
Baltimore,	Pages 1 ament of He ant: If iten ury or oth	E E I									20c. Location · 0 5 Balti		
Ball	permit Depart Import any in		21. Signature of Fu	neval Bervice Licens	ess of Facility Funeral isterstov				1117 Md				
				ne disease, or compl rt failure. List only or	ications that caused ne cause on each li	the death. Do	not enter	the mode of dyir	ng, such as cardiad	or respiratory arre	est,		Approximate Interval 8etween
	Pnysician /Medical		Immediate Cause ( disease or condition resulting in death)		Cardiac Dilation	Arrythm	ia D	ue To C	ardiomega	ly With	Biventr	icula	ar
	Examiner	_	Sequentially list con	nations,	5								
	uted d ansit	Examiner	Sequentially list confidence in any, leading to improve cause. Enter Unde Cause (Disease or that initiated events	mediate rlying injury	Due to (or as	a consequence	of):						
60,	ficate be executed physician and is the burial-transit	i Exa	resulting in death) L	Last	Due to (or as	a consequence	of):						
68760,	ficate physics the b	edical			J								
P.O. Box	that the death certiff led by the attending detached for use as	Physiclan/M	IF FEMALE: 23b. Was decedent in the past 12 1 ☐ Yes 2 ☐ 9 ☐ Unknown	months?	3c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death		ctopic pregnanc Other (specify)	y		23d. Date Mon		ry Day Year
	w requires that Ihe been signed by th should be detache		Part II. Other signif	rrhosis	ntributing to death b	out not resulting in	in the und	erlying cause giv	ven in Part I.			bute to th	e cause of death?
of Vital Records,	> 110	Completed by								24a. Was a autops perform 1 X Yes 2	y pr ned? de	ere autorior to coreath?	osy findings available npletion of cause of 2 \( \text{No} \)
Vita	Physician: this certific ral director,	Be	25. Was case reference examiner?	-	lospital:			all post Ott		ith (Check only on			
of	g Phys er this ieral di	n: To	1 XYes 2 2	no l	28a. Date of Inju		utpatient Time of Injury	3□ DOA 28c. Injui	4 Industrig n	ome 5 Reside			SCENE
Division	Attanding r death. sctor: After	1											
Divi	al or At safter o l Direct d in by	determined 206. Flace of Injury - Actionie, failit, street, factory, unice									reet and Numbe , State)	r or Hura	l Route Number,
	29a. Certifier  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and (Check only)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred a										use(s) and mar ite and place, a	ner as st	ated. the cause(s)
	To the within 2 To the complet	ž	29b. Signature and	title of certifier	4			29c. Licens		25	d. Date signed		
	v.d.			Mess			_	OCME	Š	A	PRIL 2	1, 2	005
10	A.		A		WB10,	MP	(Type, Pr		Penn Str	eet Balt	imore,	Mary	land 21201
	State Registrar APR 2 2 2005 APR 2 2 2005												

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Yeer **Physician** :40 AM 2005 MI /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 6. Sex lerci MOY ( 9. Birthplace (State or Foreign Gountry) 5. Social Security Number 7. Age (In yrs. last birthday, Funeral Hours Months 1**X** M 2□ F 31-40-1270 Yrs. Director Virginia Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiena. Important: if item 27 is marked other then "natural; or items 23a or 28a-f show any injury or other traumatic event. It a Medical Examinal for collifical at once. Maryland 1 Yes 2 □ No Director more 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2/2 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 📉 No If Yes, Give 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Mechanic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 70G rannie 19a. Informant's N. me/Relationship (Type, Print) [ Wife] 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) inden al 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ F

4 □ Donation 5 □ Other (Specify) 3 Removal from State 10h 22. Name and Address of Facility
JOSEPH L. RUSS Funeral Home, P. A.
2222 W. North Ave. Balto. Ma. 21216 21. Signature of Funeral Service Ligensee Enter the disease, or complications that caused the or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Physician Carl /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner To the Hospitel or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760 attending physiclen for use as the buria IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.0. detachad 9 Unknown 9 Unknown 23e. Did tobaceo use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 3 Probably 4 Unknown Yes 2 No Completed . Were autopsy findings available prior to completion of cause of death?

1 \( \subseteq \text{Yes} \) 2 \( \subseteq \text{No} \) 24a. Was an page 2 s autopsy perform 1∏ Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) director Hospital: Other: 1 ☐ Yes 2 🗹 No 1 Inpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA ۵ this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural 5 Pending investigation 2 🗆 No 1 Tes 2 Accident i Director: d in by the 6 ☐ Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours eft To the Funeral Di completely filled in t 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 40854 30. Name and address of person who complet of cause of death (Item 23a) (Type, Print) 30 Ballimore Risebera 22. Regist ar's Signature 31. Date filed (Month, Day, Year) State APR 2 2 2005 > Registrar

			1 - For State Registrar	State o	f Marylar		artmen rtificate					giene Reg. No./	2005	13692
	Physici		Decedent's Name (First, Middle,     Cleo Booth Johns								2. Date of De Month April	Day	Year	3. Time of Death — 10:07 PM M
	/Medio Examir		4a. Facility Name (If not institution,		mber)		4b. City,	Town, or	Location of				County of Death	
			1635 East 25th S	Street					Balti					
	Funeral Director		218-18-9107	5. Sex 1	7. Age (In yrs. 81	. last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	Min.	8. Date of Bir (Month, Da 11/17/	y, Year)	9. Birth Cour <b>VA</b>	place (State or Foreign ntry)
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. C	ity, Town or Lo	cation							10d. Inside City Limits
	Maryl -f sho	ţō	MD		Ba	ltimore								1 ∑Yes 2 □ No
	r 28a	lrec	10e. Street and Number				10f. Zip	Code				10g. Citiz	en of What Cou	ntry?
	23a c	aiD	1635 East 25th S	treet			212	13				Unit	ed Stat	es
36	d within 72 hours after death with the Maryland Jiene. r than "natural", or Itama 23a or 28a-1 show the Medical Ezzir aretmust be Lodified at	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Marrie  3 □ Widowed 4 □ Divorced	Armed Fo	2.[Σχήνίο ve		Was Deced If Yes, spec	ify Cuba	ispanic Ori n, Mexicar Specify:	n, Puerto	cify Yes or No Rican, etc.)		4. Race - Americ Black, White, Specify: Blac	etc.
응	tural		15. Decedent's	Education		16a. Dece	dent's Usua	I Occupa	ation			16b. Kin	d of Business/In	
21215-0036	within 72 ene. than "ne he Medik	Completed	(Specify only highest Elementary/Secondary (0-12)			(Give life. Clerk	kind of wor DO NOT us	rk done d se retired	turing mos I)	t of workii	ng	Reta	il	
d 2	Hyg The	a	17. Father's Name (First, Middle, L.	ast)		CICIA	<u> </u>		18. Mothe	er's Name	(First, Middle	, Maiden S	Sumame)	
<u>lan</u>	* a - 2	To B	John Booth						Loui	se H	oliman			
Maryland	es 1 and 2 should k of Health and Ment fitem 27 is marked r other traumatic e		19a. Informant's Name/Relationshi	p (Type, Print)		19b. Maili	ng Address	(Street a	and Numbe	er or Rura	l Route Numb	er, City or	Town, State, Zip	Code)
	and lealth m 27 her tr			granddau		5712			meda		imore,		1239 ation - City or To	ouen State
ore	Pages 1 nent of H int: If iter iry or oth		20a. Method of Disposition 1 Burial 2 Cremation		State	cemetery, crei	matory or o	ther plac	!	F	pr 22			
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Ba	permit. Departr Imports any inj		* Halel		BPOOM	( c	remat:	ion a	and Fu	inera.	l Alter		es more, Ma	ruland
	Fnysician /Medical Examiner	her	23a. Part1. Enter the disease, or of shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate	a	caused the dealeach line.  STAGE (or as a consector	Q EN quence of):	er the mod				r respiratory a	rrest,		Approximate Interval Between Onset and Death
ox 68760,	The law requires that the death certificate be executed tas been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	n/Medical Examiner	cause. Enter Underlying Cause (Liseace or miles) that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant	d	(or as a conse	nancy						2:	3d. Date of deliv	,
.O. B	at the death by the atte	Physician/Med	in the past 12 months? 1 □ Yes 2 MNo 9 □ Unknown		nant at time of		⊒Ectopic pr ⊒ Other (sp				_		Month	Day Year
ecords, P.	w requires that been signed to should be det	þ	Part II. Other significant condition	s contributing to c	leath but not re	sulting in the u	nderlying c	ause give	en in Part I	l. 	23e. Did		/	he cause of death?
$\alpha$		Completed									24a. Was auto perfo 1 \( \text{Yes}		24b. Were auto prior to co death? 1 ☐ Yes	opsy findings available ompletion of cause of
Vital	icien: Th certificate ector, pag	Be	25. Was case referred to medical examiner?	Hospital:				Oth	ar:		(Check only			
of	Physic this c	2	1 Yes 2 No 27. Manner of Death	1 ☐ 28a. Date	Inpatient 2	ER/Outpaties 28b. Time o		8c. Injury	4	_	ne 5 Resi 28d. Describe		Other (Special	fy)
	Attending Physicien: r death. ector: After this certification in the funeral director.	tion	1 Natural 5 ☐ Pending 2 ☐ Accident investigs	(Mor	nth, Day Year)	Injury	м .	Worl	k? Yes 2□			,		
Division	l or Attendi after death. Director: A	Certification;	3 Suicide 6 Could no 4 Homicide determin	200. Flac	e of Injury - At I ling, etc. (Spec	nome, farm, st	reet, factory	, office			28f. Location ( City or To		Number or Run	al Route Number,
	To the Hospitel or Attent within 24 hours after death To the Funerel Director: completely filled in by the	edicai C	29a. Certifier 1 Certifying (Check only 2 Medical E	Physician: To th xaminer: On the b and mar	e best of my kn pasis of examin nner stated.	owledge, deat ation and/or in	h occurred vestigation	at the tin	ne, date ar pinion, dea	nd place, a	and due to the ed at the time,	cause(s) a date and	and manner as s place, and due t	stated. o the cause(s)
	within To th compl	Me	29b. Signature and title of certifier	)			290		e number				signed (Month,	
	0		> augans	raver M.	D.			Die	6619			Apr	il 21,	2005
1	5		30. Name and address of person w  C VERGARA — 3  31. Date filed (Month, Day, Year)	ho completed cau	se of death (Ite	em 23a) (Type,	Print)	1 5	QUAR	ee p	R- BAG	TIME	RE, M	D. 21236
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)	2 2 2005	Registar's Sign	nature #	Speak	de la						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - Stata Registra Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Yea **Physician** 2005 51 Reginald Jackson OPRI /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Mercy Hospital Baltimore If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** 1/0M 2 F Director 01-08-1952 216-58-1635 Maryland Usual Residence of Decedent death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits to Health and Mental Hygiene. If Item 27 le marked other then "naturel", or Items 23a or 28a-f show or other treumetic event, the Medical Examinat must be notified at 1 yes 2 □ No **Funeral Director** Md N/ABaltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 4305 Berger Ave 21206 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after Affiled Polices? 1 ☐ Yes 2 1 1 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 FNo Specify: Specify: Black Be Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Carpet Installer Home Improvement 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be N/A ပ N/A 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tara Jackson Baltimore, Maryland 21206 4305 Berger Ave Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 Burial 2 \*Cremation 3 Removal from State ŏ Department of Importent: If any injury or once. A □ Donation 5 □ Other (Specify) Green Mount Crematory 04-20-2005 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Wise Funeral Services, P.A. 23a. Parl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 700 S. Beechfield Ave Baltimore, Maryland 21229 Approximate Interval Between Onset and Death Immediate Cause (Final Physician rchosis disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, any localing to initial additional cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Box 68760. physician s the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ģ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) P.O. signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ metustutic adenveuremona 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s nas autopsy performed? Yes 2 No certificate 1 Yes Division of Vital To the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Nospic C Hospital: 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation s after dea. 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 | Homicide within 24 hours aft To the Funeral Di completely filled in 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

State Registrar 29b. Signature and title of certifier

31. Date filed (Manp Ray Year)

Davie

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

301

32 Registrar's Signature

DHMH 17 Rev 1/2001

29c. License number

40854

29d. Date signed (Month, Dev. Year)

2005

J	2000	ı	1 - For Unpend Ite	State of 23a,27,	Marylar 28a-f	nd/Depa <b>per pae</b>	artment of F CB44 6-2 ctificate	lealth and N Death tas	Mental Hy	giene Reg. No.	005	13694
	D		1. Decedent's Name (First, Middle	a, Last)				-	2. Date of De Month	ath Day	Year	3. Time of Death
	Physici /Medio		Victor Alexis J						April	$13^{5ay}_{1}$	.005	10:54 p.™
	Examir		4a. Facility Name (If not institution					r Location of Death	1	4c. Co	ounty of Death	
			4100 block Wind					timore				
	Funeral Director		5. Social Security Number 217–17–7865	6. Sex 1 M 2 ☐ F	7. Age ( <i>In yr</i> s. 23	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da 03-20-	19. Year) 1982	9. Birthp Cour Wash	lace (State or Foreign try)  D.C.
,	and w		Usual Residence of Decedent  10a. State 10b. County		10c. Ci	ty, Town or Lo	ocation				1	Od. Inside City Limits
	death with the Maryland ms 23e or 28a-f show r must be notified at	ō,	4d Baltin	oro	D-11	kesvill	0					1 ☐ Yes 2 No
	r 28a	Director	10e. Street and Number	iore	LIL	CESVIII	10f. Zip Code			10g. Citize	n of What Cour	ntry?
	h with		4705 Mary Knoll	Road			21208			U.S.	Α.	
		Funerai	11. Marital Status	12. Was Dece Armed For	dent Ever in U	J.S. 13.	Was Decedent of H	lispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No	- 14.	Race - Americ Black, White,	
036	or it	þ	1 Never Married 2 Marr 3 Widowed 4 Divorced	ied 1 🕰 Yes It Yes, Give Year or Da	2 □ No ∍		1 ☐ Yes 2 ☐ No		o moun, etc.,	į .	pecify: Bla	
2-0	72 hours "natural", olesi Exi	sted	15. Deceden (Specify only highes	t's Education		16a. Dece	dent's Usual Occup	ation during most of work	kina	16b. Kind	of Business/Inc	dustry
Maryland 21215-0036	트 교육	Completed	Elementary/Secondary (0-12)	College (1-	4or 5+)	life.	on Jet Te	d)	ang.	Δεερ	mhle/Ma	nufactoring
d 2	filed with Hygiene other tha		17. Father's Name (First, Middle,	Last)		Wate	I SEC IC	18. Mother's Nam	ne (First, Middle,			muraccoring
lan		To Be	Victor A. Jones	Sr.				Cynthia	Helen D	ixon		
ary	d 2 should th and Men 7 is marke treumatic	-	19a. Informant's Name/Relations	hip (Type, Print)		19b. Mailin	ng Address (Street	and Number or Rui	ral Route Numbe	er, City or T	own, State, Zip	Code)
	C = 0 L		Victor A. Jones	Sr.		4705	Mary Kno.	11 Road	Pikesvi	11e.	Marvlan	d 21208
re	ges 1 and it of Health if item 27 or other t		20a. Method of Disposition			Place of Dispo	sition (Name of natory or other place		Date		tion - City or To	
Ē	Page nent o ant: If ury or		1 ∰Burial 2 ☐ Cremation  1 ☐ Donation 5 ☐ Other (S		tate	-	Chape1	1	4-2005	Roano	ke Rapi	ds N.C.
Baltimore,	permit. Pag Department Importent: It any injury o		21. Signature of Funeral Service	Licensee	No.	22	2. Name and Addre	ss of Facility Wis	e Funer	al Se	rvices,	P.A.
			23a. Part1. Enter the disease, or	complications that ca	used the dea	th. Do not ent	er the mode of dyin	ChtleId A ng, such as cardiac	or respiratory a	timor rrest,	e, Marv	1and 21229 Approximate
	Paysician		shock, or heart failure. List Immediate Cause (Final			•						Interval Between Onset and Death
7	/Medical		disease or condition resulting in death)		ple in							
н	Examiner		Convention to the securities	b								
	D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (d	or as a consec	quence of):						
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68760,	cate phys	edicai		d								
	eath certifi attending for use as		IF FEMALE:	23c. If yes, outo	come of pregn	ancy				230	d. Date of delive	in.
Box	atter affor u	by Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No		nth 2 ☐ Feta ant at time of d		Ectopic pregnancy Other (specify)	1		250		Day Year
P.O.	t the de by the a	hysi	9 Unknown	9□ Unkno	wn							
ω, σ.	res that igned b	y P	Part II. Other significant condition	ons contributing to de	ath but not res	sulting in the u	nderlying cause giv	en in Part I.	23e. Did t	obacco use	contribute to th	e cause of death?
rds	v require been sig should b	ed t							1 🗆 '	Yes 2⊠(1	No 3□Prob	ably 4 □Unknown
Division of Vital Records,	aw re	Completed							24a. Was	an 2	24b. Were autop	osy findings available inpletion of cause of
Ä	The lav	HO			-				autor perfo	rmed?	death?	
ita	sician: Th certificate rector, pag	Bec	25. Was case referred to medical examiner?					26. Place of Deal				
<b>7</b>	Physic this ce al dire	Lo L	1x Yes 2 No	Hospital: 1 □ Ir	patient 2	ER/Outpatier		4   Nursing no	ome 5 Resid	dence 6 🛭	Other (Specif)	Scene
ū	ding Ph h. After th funeral	on:	27. Manner of Death 1 □ Natural 5 □ Pendin	28a. Date of 4—1 Mont		28b. Time of 10:49	Wor	k?	28d. Describe I	how injury o	ccurred	
Sio	Attendi death. ctor: A y the fu	cat	2 Accident investig	found	-	found	- 10	Yes 2X No	subject	jumpe	ed off	bridge
)[≥	or At after of Direction by	Certification:	4 Homicide determ	ined 200. Flace buildin	g, etc. <i>(Speci</i>	iome, tarm, str fy)	ee, factory, office		City or Tov	vn, State)	umber or Mura 4100 Wil	ndsor Mill yland
_	pitei ours a erei i		29a. Certifier 1 ☐ Certifyin	g Physician: To the	hast of my kny	nwledne death	a accurred at the time	no, data and place	Rd., Ba	ltimo	re, Mar	yland
	To the Hospitel or Attenswithin 24 hours after death To the Funerel Director: completely filled in by the	Medicai	(Check only one)	Examiner: On the ba	sis of examina	ation and/or in	vestigation, in my o	pinion, death occur	rred at the time,	date and pla	ace, and due to	the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifie				29c. Licens			,	igned (Month,	
			Jasha }/	Treel	Rip		00	ME 		Apri	11 14, 2	2005
			30. Name and address of person	who completed cause	of death (Ite	m 23a) (Type,						
			31 Date filed (Month Day V	2 Moero	MU.	aturo	T11 F	enn Stre	et Balt	imore	e, Maryl	and 21201
	Sta Registr		31. Date filed (Mogth Day, Year) APR 2 2	2005	egistrar's Sign	St A	and .					

		1- State of Maryland / Department of For State of Maryland / Department of For Registrar Certificate of			ene g. No.2 0 0 5	13695
Dhusisi		1. Decedent's Name (First, Middle, Last)		2. Date of Death Month		3. Time of Death
Physici /Medic	cal	John Peter Johns		April	16 2005	648 PM
Examin	er	4a. Facility Name (If not institution, give street and number)  4b. City, Town, o  Franklin Square Hospital center Posed	or Location of Death		4c. County of Deat	
	5-		If Under 24 Hrs.	8 Date of Birth	Balti	
Funeral Director		215-28-4829 1™ 2□ F 73 Yrs. Months Days Usual Residence of Decedent	Hours Min.	8. Date of Birth (Month, Day, July 31		thplace (State or Foreign buntry) laryland
yland 30w		10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
Mar e-fsh	ctor	MD Baltimore Rosedale				1 ☐ Yes 2 🛣 No
ith the	Dire	10e. Street and Number 10f. Zip Code		10	g. Citizen of What Co	ountry?
ath w s 23a	ra	1409 Chapel Hill Drive 212			U.S.A.	
Maryland 21215-0036  d 2 should be filed within 72 hours after death with the Maryland tith and Mental Hygiene. 77 Is marked other than "natural", or Itams 23a or 28e-f show traumetic avant, the Medical Evarili er must be rediffed.	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 □ No If Yes, Sieve 1 □ Yes 2 ☑ No Year or Dates:	dispanic Origin? (Spi an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify: Wh	e, etc.
5-0	Completed	15. Decedent's Education 16a. Decedent's Usual Occup (Specify only highest grade completed) (Give kind of work done	pation	ina 1	6b. Kind of Business/	Industry
21 ithin	nple	Elementary/Secondary (0-12) College (1-4or 5+)	d)			
L 21	CO	6 Special Educa 17. Father's Name (First, Middle, Last)			Baltimore	County
2 0 m 0 %	Be	Peter Johns		e (First, Middle, M la Hatz:		
aryla should ind Men s marka umetic	ပ	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street				Zin Code)
Z 5€2 Z		Aspasia Johns 1409 Chapel 1				
s 1 ag f Hea itam othe		20a. Method of Disposition 20b. Place of Disposition (Name of			Oc. Location - City or	
Page Page net o		1 ☑ Seurial 2 ☐ Cremation 3 ☐ Removal from State  '4 ☐ Donation 5 ☐ Other (Specify)  Greek Orthodox	·	0/05 I	Baltimore,	Maryland
Baltimore, permit. Pages 1 ar Department of Hea Importent: If item any injury or othe one.		21. Signature of Funeral Service Licensee 22. Name and Addre			Zeiler &	
<b>a</b> 825 8 8		6224 Easte	ern Avenu	e Baltimo	ore, Maryl	and 21224
		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dyin shock, object failure. List only one cause on each line.	ng, such as cardiac o	or respiratory arres	st,	Approximate Interval Between
Physician /Medical		Immediate Cause (Final disease or condition a. Cor Pulmonal esulting in death)				Onset and Death
cate be executed by physician and the burial-transit	dical Examiner	Sequentially list conditions, it any learning to in models to cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	sm			3 years
.O. Box 6 the death certifi y the attending of the tree as	Physiclan/Med	IF FEMALE:  23b. Was decadent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown  23c. If yes, outcome of pregnancy  1 Live birth 2 Fetal death 3 Ectopic pregnancy  4 Pregnant at time of death 5 Other (specify)	,		23d. Date of deli- Month	very Day Year
S, P es that igned b	by P	Part If. Other significant conditions contributing to death but not resulting in the underlying cause give		23e. Did toba	cco use contribute to	the cause of death?
cords w require been sig		Acute Renal Failure, Ascite	25	1 🗀 Yes	2 No 3 □ Pro	bably 4 Unknown
I Rec The law ate has b	Completed	Coagubpathy		24a. Was an autopsy performe	eath?	topsy findings available completion of cause of
Vital F sician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	26. Place of Death			
of Vita Physician: this certifica	. To	1 ☐ Yes 2 DNo Hospital: 1 Anpatient 2 ☐ EP/Outpatient 3 ☐ DOA Oth 27. Manger of Death 28a. Date of Injury 28b. Time of 28c. Injury	ar. 4 Nursing Hor		ce 6 ☐Other (Spec	ify)
On o ding Ph h. After th funeral	tlon	1 Natural 5 Pending (Month, Day Year) Injury World	y at k? Yes 2 □ No	28d. Describe how	injury occurred	
Division  To the Hospital or Attanding within 24 hours after death.  To the Funaral Director: After completely filled in by the fune.	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined learnined 28e. Place of Injury: At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Stre City or Town,	et and Number or Rui State)	ral Route Number,
Di To tha Hospital or within 24 hours afte To the Funaral Dir completely filled in	edical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time (Check only one)  1 Medical Examiner: On the basis of examination and/or investigation, in my or and manner stated.	ne, date and place, a pinion, death occurr	and due to the cau ed at the time, date	se(s) and manner as e and place, and due	stated. to the cause(s)
To t To t com	Σ	29b. Signature and title of certifier 29c. Licenso			d. Date signed (Month	, Day, Year)
1		Mussin the Hithis MD D6	1251	A	pril 16 :	2005
841		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  DR Wassim El-Hiti 9000 Franklin Square Drive	. Baltim	iore Mo	aryland	75215
Sta Registr		31. Date filed (Month, Day, Year)  APR 2 2 1005	4.00° B			

			State of Maryland / Department of Health and N Certificate of Death		iene g. No.	05	13696
			1. Decedent's Name (First, Middle, Last)	2. Date of Deat Month		Voor	3. Time of Death
	Physic /Medi		Odessa King	4	Day 18	O 5	11:42 PM
1	Exami		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Lo		4c. County	of Death	
			Lonien Frankford Baltin				
	Funeral Director		5. Social Security Number 6. Sex 1 Months 7. Age (In yrs. last birthday) 95 Yrs.  Hours Min.  The funder 1 Year of Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day,	Year) - 19		ace (State or Foreign
	land ow		10a. State 10b. County 10c. City, Town or Location			10	Od. Inside City Limits
	Mary Feh	ğ	MD BALTIMORE PARKVILLE				·1 ☐ Yes 2 No
	r 28e	irec	10e. Street and Number 10f. Zip Code	10	Og. Citizen of	What Count	try?
	h wit	a D	2810 Erie Ave. 21234		():	54	
	ems	Funeral Director	11. Marital Status  12. Was Decedent Ever in U,S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)		e - America	
21215-0020	d 2 should be filed within 72 hours after death with the Maryland the and Mental Hygiene. 7 Is marked other then "neture!, or items 23a or 28e-f ehow treumatic event, the Medical Examinat must be notified at	by	1 □ Never Married 2 □ Married 1 □ Yes 2 1 No If Yes, Give 1 □ Yes 2 1 No Specify: Year or Dates:			wh	
5-0	72 h	Completed	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)	ina	16b. Kind of B	usiness/Ind	ustry
121	nithin ne.	ם	Elementary/Secondary (0-12) College (1-4or 5+)		7		
2	filed with Hygiene. Ither ther		17. Father's Name (First, Middle, Last)  18. Mother's Name	/Eint Middle 1	Kesta		LOT.
Maryland	d be fi	o Be	Milton C 11:11	I / St	riff L	10) 2 +=+	
<u>2</u>	2 should be end Mental s marked o sumatic eve	2	19a. Informant's Name/Relationship ( <i>Type, Print</i> )  19b. Mailing Address ( <i>Street and Number or Run</i>	el Route Number,	City or Town,	State, Zip	Code)
	nd 2 :			KVILLE	mo	212	24
ē,	s 1 and 2 f Health Item 27 i		20a. Method of Disposition (Name of	Date 2	Oc. Location -	City or Tov	vn, State
Baltimore,	Pages nent of int: If its iry or o		1 A Burial 2 U Cremation 3 U Removal from State —	1-21-05	Park	ville	mn.
Ħ	- 두두루						, , ,
ä	permi Depar Impor eny ir		21. Signature of Funeral Service Licensee  22. Name and Address of Family  BALTINORE				20.00
			23a. Part! Enter the disease, on complications that caused the death. Do not enter the mode of dying, such as cardiac of shock, or heart failure. List pniy one leaus on each line.	or respiratory arre	st,		Approximate
-	Physician	9 0	shock, or heart failure. List only one faus) on each line.			į	Interval Between Onset and Death
-	/Medical		Immediate Cause (Final disease or condition a. Neck myolardial Inforce resulting in death)	4.0		1	10
	Examiner		Immediate Cause (Final disease or condition resulting in death)  a. Norke myotardial Interconstitution for the consequence of t	,,0,,			
	το .=	Examiner	Coronary Artery Disco	180			10 4
	fficate be executed g physician and as the burial-transit	Ea					
90,	oe exe	Ê	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury to that initially described execute.				
68760,	cate t	edicai	that initiated events				
9 ×			d				
Вох	leath certi attending 1 for use a	clan					
P. O.	that the deaned by the and detached f	Physiclan/M	Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I.				the ceuse of death?
مّ	es that i igned by be deta	효	Prevnonia Enphysema	1XYe	s 2∐No	3 Probe	ably 4 ☐ Unknown
rds	The law requires that the death cert ate has been signed by the attendin, page 2 should be detached for use.	ed by	, , , , ,	24a. Was an	autopsy	24b. Wer	e autopsy findings lable prior to
ပ္တ	s bee	Completed		perioni	eur	com	pletion of cause eath?
æ	The law ate has page 2	E O		1_Y0	2/11/0	10	Yes 2∐No
<u>=</u>	sicien: The certificate irector, pag	Bec	25. Was case referred to medical 26. Place of Death	Check only one			
<u>_</u>	Attending Physicien: In death. ector: After this certific. by the funeral director,	To	examiner?  1   Yes   2D No	me 5 🗆 Resider	nce 6 🗆 Othe	er (Specify)	
0	ng Pt ter th neral		27. Manner of Death  28a. Date of Injury (Month, Day Year)  28b. Time of Injury Work?  Work?	28d. Describe hor	v injury occurr	ed	
000	endir sath. or: Af	äţi	2 Accident investigation M 1 Yes 2 No				
Division of Vital Records,	ii or Atta efter de Directa d in by t	Certification:	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Str City or Town,		er or Rural	Route Number,
	To the Hospital or Attending Phys within 24 hours either death.  To the Funeral Director, After this completely filled in by the funeral director.	edicai (	29a. Certifier (Check only one)  Certifying Physicien: To the best of my knowledge, deeth occurred at the time, date and place, and manner stated.	and due to the car ed at the time, da	use(s) and ma te and place, e	nner as sta and due to t	ted. he cause(s)
	othe outher ompl	₹ P	29b. Signature and title of certifier 29c. License number	29	d. Date signed	(Month, D	ay, Year)
			D43386		4.1	9.05	
P,	7	ŀ	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		•		21717
9	)		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Diani 1  APR 2 2 2005  32. Registrar's Signature	Place	Fil,	4° no	re mo
Ĭ	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature				
	Registr	ar	APK X X ZUUS Breve to porce				

DHMH 16 Rev 6/95

			State of Maryland / Department of Health and Certificate of Death	
			Decedent's Name (First, Middle, Last)	Reg. No.) 2. Date of Death 3. Time of Death
	Physic /Medi		BERTHA W KEY	April 17 2005 4:45
)	Exami			or Location of Death 4c. County of Death
1		P	5. Social Security Number 6. Sex 97. Age (In yrs. last birthday) If Under 1 Year If Under 24 H	for Prince Georges
5	Funeral Director			17S. 8. Date of Birth fin. (Month, Day, Year) 9. Birthplace (State or Fore Country) 9. December 3, 1915
	aryland show		10a. State 10b. County 10c. City, Town or Location	10d. Inside City Lim
	with the Marylar a or 28a-f show be notified at	햦	MARYLAND Chales BRUANS ROAD	1 □ Yes 2 □ I
	or 28	ire	10e. Street and Number 10f. Zip Code	10g. Citizen of What Country?
	ath w	la	2866 MARSHALL ROAD 20616	Le.S.A.
_	72 hours after death with the Maryland natural', or items 23a or 28a-f show asal Examiner mast be rectified as	Funeral Director	11. Marital Status  12. Was Decedent Ever in U,S. Armed Forces?  1 □ Never Married 2 □ Married  11. □ Yes ≥ 2 □ Mo  13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu	(Specity Yes or No- erto Rican, etc.) 14. Race - American Indian, Black, White, etc.
020	urs aff	þ	1  Never Married 2  Married 1	Specify:
21215-0020	72 hour "natural"	Completed	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of w	16b. Kind of Business/Industry
121		nd m	Elementary/Secondary (0-12) College (1-4or 5+) life. DO NOT use retired)	vorking
	e filed within al Hygiene. I other then '	ပ္ပ	12 School Leachel  17. Father's Name (First, Middle, Last)  18. Mother's N	Educational System
Maryland	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other then may highry or other freumatic event, the Monce.	To Be	HARRY Williams Rose	lame (First, Middle, Maiden Surneme)
ary	2 shou and M Is mar eumat	-	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or	Rurel Route Number, City or Town, State, Zip Code)
	and 2 ealth in 27 i		JOAN MIMS/DAUGHTER 2866 MARSHALL ROAD	BRYANSROAD, MD 20616
ore	ges 1 t of H If iter or oth		20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)  3 □ Removal from State	Date 20c. Location - City or Town, State
Baltimore,	permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any Injury or other treu ongs.		4 Donation 5 Other (Specify) METROPOLITAN Church	14-21-05 BRYANS ROACL BRENT
Ba	permit. Departn Importa any Inju		21. Signature of Funeral Service Licensee  22. Name and Address of Facility	
	ś		23a Part Frier the diffe of the squeed the death De sol at the squeed It	ome P.A. Agunsco, MD.
	Physician	( )	23a. Part 1. Enter the disease, or compile tions that caused the death. Do not enter the mode of dying, such as cardi shock, or heart failure. List only one cause on each line.	Onset and Death
1	/Medical		Immediate Cause (Final disease or condition Confestive Least Failer	2
	Examiner	Ŀ	resulting in death)  Due to (or as a consequence of)	
Т	nsit	Examiner	o. Chronic remail dise	
ó	exect an and nal-tra		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury c. UPF CI Bloodry	
68760,	rificate be executed ng physician and as the bunal-transit	licai	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	
39 ×	entifica ding pl	Mec	d HTW.	
Box	The law requires that the death certificate be executed the best been signed by the attending physician and page 2 should be detached for use as the bunal-transit	Physiclan/Medical		
P. 0.	v requires that the de been signed by the should be detached	hysi	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23b. Did tobacco use contribute to the cause of death
S,	gned I	by P	CVA.	1  Yes 2 No 3 Probably 4 1 Unknown
ord	equire een si	ted	LVA.  decub, ti	24a. Was an autopsy performed? 24b. Ware autopsy findings available prior to
ည် နှင့်	e law r hes be je 2 sh	Completed		completion of cause of death?
<u>=</u>	: The la			1 Yes 2 No 1 Yes 2 No
Division of Vital Records,	Physician: this certifioral director,	o Be	Hospital:	eath (Check only one)
٥	g Phy er this eral d	٦. ح	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury et	Home 5 ☐ Residence 6 ☐ Other (Specify)  28d. Describe how injury occurred
Ö	Attending I or death. ector: After by the funer	atio	2 Accident investigation M 1 ☐ Yes 2 ☐ No	
Ĕ	l or Atten after deat Director: I in by the	Certification:	3 ☐ Suicide 4 ☐ Homicide  1 ☐ Could not be determined  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
	To the Hospital or Attending Physician: The within 24 hours atter death.  To the Funeral Director. After this centificate completely filled in by the funeral director, pag		29a. Certifier 1 Certifying Physician: To the best of my knowledge death occurred at the time date and also	
	e Hos	edical	29a. Certifier (Check only one)  1□ Certifying Physician: To the best of my knowledge, death occurred et the time, date and place    2□ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place    2□ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place    2□ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place    2□ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place    2□ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place    2□ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place    3□ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place    3□ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place    3□ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place    3□ Medical Examiner: On the basis of examination and occurred at the time, date and place    3□ Medical Examiner: On the basis of examination and occurred at the time, date and place    3□ Medical Examiner: On the basis of examination and occurred at the time, date and place    3□ Medical Examiner: On the basis of examination and occurred at the time, date and place    3□ Medical Examiner: On the basis of examination and occurred at the time, date and place    3□ Medical Examiner: On the basis of examination and occurred at the time, date and place    3□ Medical Examiner: On the basis of examination and occurred at the time, date and place    3□ Medical Examiner: On the basis of examination and occurred at the time	e, end due to the cause(s) and manner as stated. curred at the time, date and place, and due to the cause(s)
	To the within 2 To the Complet		29b. Signature and title of certifier 29c. License number	29d. Date signed (Month, Day, Year)
			K. Danal 2 30 D25640	HORI 17 2005
/	31	-	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	
	<i>}</i> Stat	6	DR Khoslow DAYACHI 1328 SouthERN AYE SE WI 31. Date filed (Month, Day, Year) 32. Registrar's Senature APR 2 2 2005 Leave & Spark	ashington, D.C 20032
	Registra	~	APR 2 2 2005 Blown It Spell	

			1 - For State of Mar State		artment <i>rtificate</i>			and M		Reg. No.	.UU.	)	13698
	Physici	an	1. Decedent's Name (First, Middle, Last)  Marcolla Lorraine Kingsinger						Date of Dea     Month		Yea	ar	3. Time of Death
	/Medic	cal	Marcella Lorraine Kissinger  4a. Facility Name (If not institution, give street and number)		4b. City, To	num ost	continu a	f Dooth	APRIL	Day l &	/		6:40 PM
	Examin	ier	Union Memorial Hospital			timo		T Death		40.	County of De	eath	
-	Funeral		5. Social Security Number 6. Sex 7. Age	(In yrs. last birthday)	If Under 1	Year	If Under 2		8. Date of Birt (Month, Da	h ,	9. E	Birthpla	ce (State or Foreign
	Director			75 Yrs.	Months	Days	Hours	Min.	8/13/	1929		Country	aly
	and w		Usual Residence of Decedent           10a. State         10b. County	IOc. City, Town or Lo	cation							100	d. Inside City Limits
	Mary -f sho	to	MD Baltimore	-								,,,,	1 □ Yes 2 □XNo
	r 28a	Director	10e. Street and Number	Arbuti	10f. Zip C	ode				10g. Citi	zen of What	Country	y?
	23a c	ai D	939 Regina Drive			2122	7			US	SA		
	ar dea	Funeral	11. Marital Status 12. Was Decedent Ev Armed Forces?	er in U.S. 13. \	Was Deceder	nt of Hisp Cuban,	oanic Orig	in? (Spe , Puerto	cify Yes or No- Rican, etc.)		14. Race - Ar Black, W.		
36	rs afte	by F	1 ☐ Never Married 2 ☒ Married 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	1	1 □ Yes 2 □		Specify:				Specify:	Whi	
9-0	72 hours after death with the Maryland Instural, or frams 23e or 28e-f show diest Exeminer must be notified at		15. Decedent's Education	16a. Deced	dent's Usual (	Occupati	ion			16b. Kii	nd of Busine	ss/Indu	strv
218	within 7 ene. than "n	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	(Give	kind of work DO NOT use	done dui retired)	ring most	of workii	ng				,
21	e filed within al Hygiene. I other than "	Con	12 n/a	Sean	nstres						Cloti	ning	J
and	d be fi	Be	17. Father's Name (First, Middle, Last)  Cesare Panichi			1			(First, Middle,	Maiden	Sumame)		
Maryland 21215-0036	2 should be and Mental Is markad o	To	19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	na Address (S	Street and		na L	OM1 I Route Numbe	r City o	Town State	Zin C	nde)
Ma	1 and 2: Health ar tem 27 Is		Charles T. Kissinger-Spouse						utus, M			, <i>LIP</i> O	000
Baltimore,	permit. Pages 1 and 2 should be filled within 72 hours after death with the Marylan Department of Health and Mental Hygiens. Important: If time 27 is marked other than "natural, or itams 23a or 28a-f show any injury or other traumatic event, It's Madical Exemples must be notified at once.		20a. Method of Disposition	20b. Place of Dispo	sition (Name	of er place)		D	ate	20c. Lo	cation - City	or Town	ı, State
Ē	Page ment ant: If ury o		1X Burial 2 ☐ Cremation 3 ☐ Removal from State  4 ☐ Donation 5 ☐ Other (Specify)	cemetery, crem Meadowri Memorial F					/2005	Elk	ridge	, ME	)
3alt	permit. Depart Import any inj		21. Signature of Funeral Service Licensee	22 M <i>e</i>	Name and	Address	of Facility	Ga	ry L. K l Park.	aufm	ian Fur	nera	I Home at
	0.013.6104		23a. Part1. Enter the disease, or complications that caused th						d., Elk		ie, MD		)75 pproximate
	Medical Examiner the principle of the pr	dicai Examiner	Due to (or as a c									Ö	iterval Between Inset and Death
P.O. Box 687	It the death certific by the attending p ached for use as	Physician/Medio	IF FEMALE: 23b. Was decedent pregnant in the past 12 menths? 1  Yes 2 No 9 Unknown  23c. If yes, outcome of 1 Live birth 2 1 4 Pregnant at time 9 Unknown	Fetal death 3	Ectopic preg					2	3d. Date of d Month	lelivery Da	ay Year
Ś	quires tha	by	Part II. Other significant conditions contributing to death but if  ALZHEIMER'S DEME		nderlying cau:	se given	in Part I.		23e. Did to	/			cause of death?
Division of Vital Record	e law requir has been s je 2 should	Completed	PHEUMONIA						24a. Was a		24b. Were	autopsy	findings available letion of cause of
Ä	The I	Com							autops perfor		death?	,	No
Vita	ysician: Th is certificate director, pag	Be	25. Was case referred to medical examiner?					of Death	Check only or				
of	Physic this cral dir	- To	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 27. Manner of Death 28a. Date of Injury			Other: Injury at	4   Nur		ne 5 Reside			ecify)	
0	al or Attending Phy after death. I Director: After this d in by the funeral o	Certification:	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation  28a. Date of Injury (Month, Day Y	(ear) Injury	М	Work?	s 2 □ N		8d. Describe h	ow injury	occurred		
Visi	Atter	ifica	3 Suicide 6 Could not be 28e. Place of Injury	- At home, farm, stre	eet, factory, o	ffice		2	8f. Location (S	treet and	Number or F	Rural R	oute Number,
	tal or rs afte al Dir ed in	Cert	4 Homicide building, etc. (	эрөспу)					City or Tow	n, State)			
	he Hospi n 24 hou he Funer pletely fill	edical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of real manner: On the basis of examiner: On the basis of examiner stated	kamination and/or inv	occurred at restigation, in	he time, my opini	date and ion, death	place, a occurre	nd due to the c d at the time, d	ause(s) a ate and	and manner a place, and du	as state	d. e cause(s)
	To t To t	Ž	29b. Signature and title of certifier			icense n					signed (Mor		
			·			005	5834	9		APR	16/8,	200	5
	12		30. Name and address of person who completed cause of deal EDMUND A. TORI, D.O. 201 E.	th (Item 23a) (Type, F		RAI	TIME	200	111 210	14			
	Stat Registra		31. Date filed (Month, Day, Year) APR 2 2 2005	Signature	ale	3/(		, ,	1412 61	20			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** MIARGARET 6.15 pm 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Northwest Hospital 5401 Old Court Randalktown Battimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 6 Sex Funeral 8. Date of Birth (Month, Day, Year) Birthptace (State or Foreign Country) Days Hours 1 ☐ M 25 F Director 212-28-7286 Feb. 11, 1929 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or itema 23a or 28e-f show any injury or other traumatic event, the Medical Examples must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Directo Maryland Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9133 Santa Rita Road 21236 Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2☐ Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Yes 2 ☑ No þ 3 ☐ Widowed 4 ☐ Divorced Specify: White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 years Home Maker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Otto Forster Marie Noderer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George K. Kraft (Husband) 9133 Santa Rita Road Baltimore, Maryland 21236 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Dulaney Valley Mem. Gdns. 4/21/05 Timonium, Maryland \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Avenue Dundalk, Maryland 21222 ones Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Immediate Cause (Final disease or condition resulting in death) Flysician pneumong /Medical Examiner thicily resistant Stephylowice owney Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner signed by the attending physician and d be detached for use as the burial-transit Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ Chronie O Structure lune dieas 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death Check onl one Hospital: 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification; 1 A Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 - Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier and manner stated.

To the Hoapital or Attanding within 24 hours a To the Funeral C

After t

death.

after death

The law requires that the death certificate be executed

Records, P.O. Box 68760

Division of Vital

with the Maryland

State Registrar

31. Date filed (Month, Day, Year) 32. Registrar's signature 2005

( Danganaja

29b. Signature and title of certifier

Lame swam

30 Name and address of person who completed cause of death (Item 23a) (Type, Print) Kangarager

Hospital

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items 28a-F per ME, G842, 04, 21, 05 db and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year APAIL 17:40 PM Dennis Liberto 2000 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** SINAL HOSPITHL OF BACTIMORE BALTIMORE If Under 1 Year | If Under 24 Hrs. Hours | Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year)
Aug. 21,1948 Birthplace (State or Foreign Country) **Funeral** 1⊠M 2□F Yrs Director 217-50-9610 56 Maryland Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits other traumatic avant, the Medical Examiner must be notified at 1√XYes 2 No Directo Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with Івтя 23а 8 Clear Skies Court Apt 101 21209 U.S.A. Completed by Funeral 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married ŏ Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify 3 ☐ Widowed 4 € Divorced "natural" White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry d 2 should be filed within 7/ h and Mental Hygiene." 7 is markad other than "n College (1-4or 5+) Elementary/Secondary (0-12) 12 Restaurant Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Lena T. Cardinale Santo Liberto 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 sinent of Health an itam 27 Santo Liberto (Father) 5005 Wilkens Avenue Catonsville, Maryland 21228 Baltimore, 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State cemetery, crematory or other place) 0 1 

Burial 2 □ Cremation 3 □ Removal from State Department of Important: If eny injury or once. 1 4 ☐ Donation 5 ☐ Other (Specify) New Cathedral Cem. 4-12-2005 Baltimore, Maryland 21. Signature of Euneral Service 1 22. Name and Address of Facility Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Ave. Catonsville, Maryland 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final UPPER AIRWAY Physician OBSTRUCTION disease or condition resulting in death) thikiod in Te /Medical Due to (or as a consequence of) Examiner FOOD ASPIRATION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) ON APPROVED BY MEDICAL EXAMINER The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760 Physician/Medical CERTIFICA IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. 1 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. à 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 1 ☐ Yes 2 ☐ No 2 No 1 Yes Physician: funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 DER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 es 2 No Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After or Attanding 5 Pending 1 Natural Choked on bolus of food 1 Yes 2 No death. April 7,2005 2 Accident investigation Unk .P M after death Diractor: the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
School

28f. Location (Street and Number or Rural Route Number)
School, Shrine of the Sacred Heart
School, Baltimore, MD

12 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 6 Could not be determined 3 ☐ Suicide filled in by 4 - Homicide To the Hospital within 24 hours at To the Funeral C 29a. Certifier Medical (Check only one) 29c. License number 29b. Signature and title of certifier 29d, Date signed (Month, Dav. Year) APRIL 7, 2005 D0029250 - WN 8 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

Denny Libert

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to

DHMH 17 Rev 1/2001

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APR 2 1 2005

31. Date filed (Month, Day,

ULUESS

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32. Registrar's Signature

2401 WEST BELVEDERE NE, BALTIMORE ND

			for State Registrar	State of Ma	aryland / D		t of H	lealth a	and M			OF	1 0 100
		(Se	1. Decedent's Name (First, Middle, Last,							2. Date of Death	6	U 9 -	3. Time of Death
	Physici /Medic		CHARLE	3 5 1 5	FFKO	WITT	>			Month APRIL :	Day ZOCA Z	Year	0 05 AM
	Examir		4a. Facility Name (If not institution, give	street and number)				Location of		men, o	4c. County		2:05 AM <sup>M</sup>
W.			Saint Joseph Hosp			_	owso				Balt	imore	
	Funeral		Social Security Number     6. Security Number		e (In yrs. last birth		1 Year	If Under		8. Date of Birth			ace (State or Foreign
	Director			M 2□F	61 Y	rs. Months	Days	Hours	Min.	(Month, Day, 10/4/19			yland
	pu 🛊		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town								
	sho	'n	MD N/A		- 77							10	d. Inside City Limits
	the N	ect	10e. Street and Number		Balti								1 X Yes 2 No
	with sor	Σ	1117 Evans Way			10f. Zip		205		109	g. Citizen of V		ry?
	leath	<b>Funeral Director</b>		12. Was Decedent E	ver in U.S.	13 Was Doop			gin? (Snor	offu Van or No	U.S.	A . e - America	n Indian
10	fter o	Fun	1 ☐ Never Married 2 ☑ Married	Armed Forces? 1 ☐ Yes 2 ☐ N		If Yes, spe	offy Cuba	in, Mexican	n, Puerto R	cify Yes or No- lican, etc.)		k, White, e	
036	urs a	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 🗆 Yes	2 🔀 No	Specify:			Specify	Whi	te
2-0	72 hours after death with the Maryland netural, or Itams 23s or 28s-f show Alcal Exertinest be molified at	Completed by	15. Decedent's Edu (Specify only highest grade	cation	16a. [	Decedent's Usu	al Occupa	ation		16	6b. Kind of Bu		
2	thin thin	nple	Elementary/Secondary (0-12)	College (1-4or 5	+)	Give kind of wo life. DO NOT u	rk done d	during most !)	t of workin	g			
2	ed wi	Con	12		S	teel Wo	rker				Stee1	Comp	any
lnd	be fill d out	Be	17. Father's Name (First, Middle, Last)	C				18. Mothe	er's Name	(First, Middle, Ma	aiden Sumam	e)	
$\frac{1}{2}$	ould Men Marka Marka	To	Paul H. Lefkowitz							May Hi			
Maryland 21215-0036	pernit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depurtment of Health and Mental Hygiene. Important: If item 27 is marked other than "netural", or Items 23s or 28a-f show any injury or other traumatic event. It medical Exercit at most be notified at once.		19a. Informant's Name/Relationship (Ty) Inez Lefkowitz/Wif							Route Number, (			Code)
	is 1 and 2 of Health a itam 27 is other trau			e				ay Bai		re, Mar			
Baltimore,	ges it of the If its		20a. Method of Disposition  1X Burial 2 ☐ Cremation 3 ☐ R	emoval from State		, crematory or o	ne of ther place				c. Location -	City or Tow	n, State
ij	t. Pa rtmer rtant: rjury	3	'4 □Donation 5 □ Other (Specify)		Holly	y Hill		1 4	4/23/	05 1	Baltimo	ore, l	Maryland
Ba	Depution of the control of the contr	ļ ļ	21. Signature of Euneral Service License			22. Name an	d Addres	s of Facility	yMill	er-Dippe	el Fune	eral I	Home Inc.
			222 Part Fator the disease or an		the death Death	0415	se_a:	ir Roa	<u>ad Ba</u>	<u>ltimore</u>	. Marv	Land :	21206
			23a. Part1. Enter the disease, or complishock, or heart failure.	e cause on each lin	e.	it enter the mod	e of dying	g, such as o	cardiac or	respiratory arres	t,	1	Approximate nterval Between Onset and Death
	Fnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	ISCHE		CARDI	040	40 PF	ATHI	4			years
	Examiner				consequence of	•	0 -	1000			// a =		
		e	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	CONSEQUENCE OF	):	Kon	OHAC	4 10	RYERL	1015	BAS	
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	DI DI	BETES	MA	1.17	125				4	ears
o,	exec an an rial-tr		resulting in death) Last		consequence of						<u>-</u>		
8760,	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/Medical											
9	death certifica attending ph	Med	IF FEMALE:										
Вох	ath ce tendi	an/l	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of 1 ☐ Live birth 2		3 Ectopic pr	egnancy					of delivery	
	the a	sici	1 Yes 2 No	4□Pregnant at t 9□Unknown	ime of death	5 Other (sp	ecify)				Mon	ith L	ay Year
P. O.	that the de led by the a detached t	P F	Part II. Other significant conditions con	tribustina ta da atu bu	A == A == (A) = = ( - A					00 PIVI			
S,	ires tha signed d be det	by	Farm. Other signmeant conditions con	mboting to death bu	t not resulting in t	ne underlying c	ause give	ın ın Paπ I.					cause of death?
Ö	w require been si should b	etec								T Tes	2 LI NO		bly 4 Unknown
Records,	e law has b	Completed						_		24a. Was an autopsy	l p	rior to comp	y findings available detion of cause of
a	ician: The l certificate ha rector, page									performe	No 1	eath? □Yes 2	□ No
Vital	Physician: this certifica	Be	25. Was case referred to medical examiner?	ospital:			Otho			Check only one)			
ot	Physician: r this certifica	- To	1 Yes 2 No	1 ☐ Inpatien	ER/Outp	-	A Cure	4 Nur	rsing Home	5 Residence	e 6 Othe	r (Specify)	
Division of	ling Afte une	ertification:	1 Natural 5 Pending 2 Accident investigation	(Month, Day	Year) Inju	iry M	Bc. Injury Work	al ? ′es 2 □ N		d. Describe how	injury occurre	90	
/ISI	il or Attandii after death. Director: A d in by the fu	fica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injur	ry - At home, farm				_	f. Location (Stree	et and Numbe	r or Bural F	Route Number
2	after Dire	erti	4  Homicide determined	building, etc.	(Specify)	, otroot, ractory	, 011100			City or Town, S	State)	i or ribrarr	ioule Number,
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	Salc	29a. Certifier 1 Certifying Phys	icien: To the best of	my knowledge, o	death occurred	at the time	e, date and	place, an	d due to the caus	se(s) and man	ner as stat	ed.
	n 24 n 24 n 24 su 5u 5u 5u 5u 5u 5u 5u 5u 5u 5u 5u 5u 5u	edical	(Check only 2 Medica! Examination)	er: On the basis of and manner state	examination and/	or investigation,	in my op	inion, death	h occurred	at the time, date	and place, a	nd due to th	ne cause(s)
	To t To tl com	Σ	29b. Signature and title of certifier			29c	License	number		29d.	Date signed	(Month, Da	y, Year)
			Spepte	MD		Do	05	3154	0	AF	121C 2	CON	2005
6			30. Name and address of person who cor	npleted cause of de	ath (Item 23a) (Ty	/pe, Print)					A	10	
V .	)		SHAKUNMARA	mpleted cause of de GOPTA M 32. Registrar	10,17	00 46	ORL	e ize	DAD	7065	ON :	2120	74
	Stat Registra		31. Date filed (Month, Day, Year)	32. Registrar	's Signature	L A	Land.	,		(			
	negistra	1	APR	2 2 2005	FRAGILES	10 16	A						

			1 - For State Registrar	State of Ma	ryland / [		artmen tificate			and M	_	giene Reg. No.	005		3702
	Physici /Medi		Decedent's Name (First, Middle, Last,     Carroll Paul	Marinelli							2. Date of De Month April	Day	Ye:	ar	3. Time of Death
	Examir	ner	4a. Facility Name (If not institution, give Union Memorial  5. Social Security Number 6. Se.	Hospital	//		2.	alti	Location o		/		County of D	Ά	
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	e Marylan 3a-f show Illind at	Director	10a. State 10b. County  Maryland Baltimo.	1	10c. City, Tow		cation Balti	more						10d	Inside City Limits 1 ☐ Yes 2 ☑ No
	ath with th		10e. Street and Number 9225 Gardenia Ro	ad			10f. Zip	Code	2123	6			en of What		?
1036	within 72 hours after death with the Maryland ene. than "natural", or Itams 23a or 28a-f show ha Madical Evarniter musi be rotified at	by Funeral	11. Marital Status  1 □ Never Married 2 🛣 Married  3 □ Widowed 4 □ Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:			Was Deced fYes, spec I□Yes 2		spanic Orig n, Mexican Specify:	gin? (Spe , Puerto	ecify Yes or No Rican, etc.)	1	4. Race - A Black, W Specify: (	/hite, etc	
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Marylan I Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Exeminat must be rotified at	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)		)	(Give	lent's Usua kind of wor DO NOT us 'LMACÚ	k done d e retired)	urina most	of workii	ng	Pha	of Busine rmaci G-Emp	st	•
ryianu	should ba tile nd Mental Hy markad oth imatic event	To Be (	17. Father's Name (First, Middle, Last)  Frank Marinel		1				Lo	uise		eccio			
	ss 1 and 2 sho of Health and item 27 is my other traums		19a. Informant's Name/Relationship (Ty Mrs. Edith J. Mar 20a. Method of Disposition		(6e) 9:	225 f Dispos	Gard	enia	Road	, Ba	l Route Numbe Ltimore	e, MD		6	
Baltimore,	permit. Pages of Department of Himportant: If ite any injury or ot once.		1 X Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Incensi		Garde	ns c		ith	4		2005 imunek	Balt	imore	, Ma	ryland
ñ E	Dep Imp		23a. Part1. Enter the disease, or compli	cations that caused the	ne death Do	97	105 B	elai	r Rd.	<b>,</b> Ва	ltimore	e, MD		6	pproximate
	Pnysician /Medical		shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	me cause on each line  Me fabe  Due to (or as a	olic u	acio								1ni	erval Between nset and Death 12 hour
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9/00,	cate be executed physician and the burial-transit	dical Exar	that initiated events resulting in death) Last	Due to (or as a	consequence	of):						-			
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_	w requires that baan signed b should be deta	þ	Part II. Other significant conditions cor	ntributing to death but	not resulting in	n the un	derlying ca	iuse give	n in Part I.						ause of death?
מו שבככ		Completed											24b. Were prior to death	o comple	findings available etion of cause of No
Division of vital Records,	d is	ition: To Be	25. Was case referred to medical examiner?  1 □ Yes 2 ☒ No  27. Manner of Death  1 ☒ Natural 5 □ Pending 2 □ Accident investigation	lospital: 1 🛣 Inpatient 28a. Date of Injury (Month, Day)	28b. T	itpatient Fime of njury		Bc. Injury Work	4 □ Nurs	sing Horr	Check on one 5 ☐ Residence Residence Property of the Check of the Check of the Check of the Check of the Check on the Che	dence 6 (	□Other (Sp	pecify)	
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc.	r - At home, fa: (Specify)	ım, stre	et, factory,	office		2	8f. Location (S City or Tow	Street and i vn, State)	Number or	Rural Ro	oute Number,
	To the Hospital or Att within 24 hours after d To the Funeral Direct completely filled in by	edical (	29a. Certifier 1 ☑ Certifying Phys (Check only one) 2 ☐ Medical Examir	sician: To the best of ner: On the basis of e and manner state	d.	d/or inv	estigation,	in my opi	nion, death	occurre	d at the time, o	date and p	lace, and d	ue to the	cause(s)
	Withi To II	M	29b. Signature and title of certifier  Rochammad	Surgical	Resider	ri	29c.	License 24	number 5894	6 - E	19	29d. Date :	signed (Mo	nth, Day	8, Balt,
9			30. Name and address of person who co	mpleted cause of dea	th (Item 23a) (	(Type, F	Print)	405/21	tal 2	201 1	E. Univ	ersi	MD 1 ty Pri	2121 zwy.	8 , Balt,
B	Sta Registr		31. Date filed (Month, Day, Year) APR 2 2 2001	3 Registrar	s Signature	A.	AP a								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Dav Year 8:00) AM Maszun trua /Medical 2005 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death ente If Under 1 Year If Under 24 Hrs. TIMORE 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 1□M 200F -46-4856 Days Hours Yrs. Director HUSTRIA Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is markad othar than "natural", or Itams 23a or 28a-f show traumatic evant, I're Modical Examiner must be natified at 1 ☐ Yes 2 No Director BALTIMORE utherville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? SA Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 Is marked other then "natural", or Ite 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 20 No White Completed by Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 OWN nome 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Proeller ၉ Franz Mueller aria 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HItred 20b. Place of Disposition (Name of cemetery, crematory or other place) Lutherville MD 21093 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Valley Men Gardens 4-23-05 Timonium MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lieensee 22. Name and Address of Facility YORK RO., Timonion mb. Kimberly PEACEFUL ALTERNATIVES FUNCICAL "CREMATION CENTER 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ovarian meritus Canco /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed attending physicien and for use as the burial-tran Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 👿 No Month Dav Year 4□Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. been signed by the should be detached Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 No 1 Vinknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No 24a. Was an autopsy performed? 2DONo director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 2 1 ☐ Yes 2 No 4 Nursing Home 5 Residence 6 DOther (Specify) NOSPICO 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident investigation after death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 20 2005 April 30. Name and address of person who completed cause of death (Item 23a) Type, Print) & & + Beltune mo 2/204

Registrar

DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year) APR 2 2 2005

MASzun, Edel Hude

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			1 - For State Registrar			icate of			Reg. No. 0	05	13704
	Physici /Medio		1. Decedent's Name (First, Middle, La	JE MICNU				2. Date of De Month	Day 18 :	Year 2005	3. Time of Death 2: ZSPM
	Examir	ner	4a. Facility Name (If not institution, giv	,			MORE	th	4c. Cour	ty of Death	
	Funeral Director		5. Social Security Number 6. S 212-36-5829		last birthday) If	Under 1 Year onths Days	If Under 24 Hrs Hours Min		h y, Year) . 1938	9. Birthp	lace (State or Foreign try) RYLAND
	yland now		Usual Residence of Decedent  10a. State  10b. County	10c. Ci	ty, Town or Locati	on				1	0d. Inside City Limits
	Ba-f st	ctor	MD BALTI	MORE YA	RKVIL					(1)	1 ☐ Yes 2 No
	with th	Funeral Director	3308 L MON	INF AF		10f. Zip Code	24		10g. Citizen o	SA	try?
	me 2	nera	11. Marital Status	12. Was Decedent Ever in L Armed Forces?	J.S. 13. Was	Decedent of H	dispanic Origin? (S an, Mexican, Puer	Specify Yes or No to Rican, etc.)	14. R	ace - Americ	
036	72 hours after death with the Maryland "natural", or iteme 23a or 28a-1 show safeal Examilier of the modified at	by	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 █ No If Yes, Give Year or Dates:	i	Yes 20 No	Specify:		Spec	ify: W	ATTE
215-0036	72 ho	eted	15. Decedent's E (Specify only highest gra	ducation ade completed)	16a. Decedent	's Usual Occup	pation during most of wo	nrking	16b. Kind of	Business/Inc	Justry
1212	withir ene. than	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	HON	AE M	AKER		$\bigcirc$	CC	HOME
מפי	調子等は	Be C	17. Father's Name (First, Middle, Last	)	/		18. Mother's Na	me (First, Middle	Maiden Sum	ame)	
Maryland	should be nd Mental marked o	ဥ	19a. Informant's Name/Relationship (	Type Print) Hands	19h Mailing A	ddress /Street	and Number or R	ural Route Numb	LSEK	n State Zin	Ocode) 21234
	od 2 stranger treu		STANLEY MONO	LI45R	330	8 W	DIECO	EAVE	. Pack	WILLE	EMD
Baitimore,	Pages 1 au nent of Hea int; if item iry or othe		20a. Method of Disposition	Perpoyal from State	Place of Disposition cometery, cremator	on (Name of ory or other place	ce) 4·2;	Date 2. 2005	20c. Location	- City or To	wn, State
	permit. Pages Department of i importent; if it eny injury or o		' 4 ☐ Donation 5 ☐ Other (Special 21. Signature of Funeral) Service Licer			EMETE ame and Addre	24		tack.	CE W	EMORIES
n	Deprime sony		14	Morzza	000	and the same					D 21234
	Physician /Medical Examiner	liner	23a. Part1. Enter the diseast, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. List of the property of the conditions.	b. Due to (or as a consec	quence of):						Interval Batween Onset and Death
68/60,	ificate be executed g physician and as the buriat-transit	edicai Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C. Due to (or as a consect	quence of):						
C. Box	The faw requires that the death certificate tie has been signed by the attending physioage 2 should be detached for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of o	al death 3 □Eci	opic pregnancy her (specify)	/			ate of delive	ry Day Year
1.	res that igned b	by	Part II. Other significant conditions		-	rlying cause giv	ren in Part I.				e cause of death?
cords,	w require been sig should t	eted	Metantatic Br	east Cance	1			24a. Was			ably 4 Onknown
Y Y	sicien; The law certificate has l irector, page 2 s	Completed						autor	rmed?	prior to con death?	osy findings available npletion of cause of 2 No
VItal	Physicien; r this certifica ral director, p	Be	25. Was case referred to medical examiner?	Hospital:		Oth	0.5	ath (Check only o			
ō	Phy this ral d	To :r	1 ☐ Yes 2 ☐ No 27. Manner of Death	28a. Date of Injury	28b. Time of	3□ DOA Oth 28c. Injur Wor	4   Nursing i	Home 5 ☐ Resident Re			2
010	or Attending Puter death. Director; After in by the funera	ation	Natural 5 Pending investigatio		Injury		Yes 2 □ No				
DIVISION	el or Attendir s after death. si Director; Af ad in by the fu	Certification;	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined			factory, office		28f. Location (: City or To		nber or Aura	l Route Number,
	To the Hospitel o within 24 hours aft To the Funerei Di completely filled in	Medical (		nysician: To the best of my kniner: On the basis of examinating and manner stated.							
	To the vithin To the compl	Me	29b. Signature and title of certifier	10		29c. Licens			29d. Date sign		
	4		1 6 Bouge	ily, M.D			5306		04/.		
i	0		30. Name and address of personnel.	nomel ed cause of death (Ite							
Ú	Sta Registr		31. Date filed (Month, Day, Year)	32. Degistrar's Sign	ature Ana	L)	bell a rolle &	1 60136	p. 24.3/har/1	1	ل دیدا ــــــــــــــــــــــــــــــــــ
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			1 - State Registrar	State of Marylan		artment of H					
	Physici		Decedent's Name (First, Middle, Last)	man Mr	uis.			2. Date of De	ath Day	Year Year	3. Time of Death
	/Medio Examir		4a. Facility Name (If not institution, give st. 5heppard Pry		70,3	4b. City, Town, o		Death	4c. Cou	nty of Death	OPE
	Funeral Director	!	5. Social Security Number  216-28-3416  Usual Residence of Decedent	7. Age ( <i>In yrs.</i> 7. Age 7. Age ( <i>In yrs.</i> 7. Age 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs</i>	- "	If Under 1 Year Months Days		Min. (Month, Da	th		ace (State or Foreign ry) .MD
	Maryland	ctor	10a. State 10b. County  Maryland Anne Art		ty, Town or Lo		polis			10	od. Inside City Limits 1 ☐ Yes 2 ☑ No
	with the a or 28 be not	Director	10e. Street and Number 919 Berwick Drive			10f. Zip Code			•	of What Count	ry?
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other then "natural", or items 23s or 28e-f show any injury or other traumatic event, It a Modical Examinar must be notified at once.	by Funerai	11. Marital Status 12 Married 1 Never Married 2 Married 12 Marrie	. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give	1		403  Iispanic Origin an, Mexican, P	? (Specify Yes or No Puerto Rican, etc.)	- 14. F	USA Race - America Black, White, e city: Whit	itc.
21215-0036	n 72 hour "natural" adical Ex	leted b	3 ☐ Widowed 4 ☐ Divorced  15. Decedent's Educa (Specify only highest grade	Year or Dates: ation completed)	16a. Deced	lent's Usual Occup kind of work done	during most of	f working		f Business/Indu	
	filed withii Hyglene. Ather then ant, IDe M	e Completed	Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Last)	College (1-4 <i>o</i> r 5+)		1 Estate	Broker	Name (First, Middle,	Build	ing & D	evelopment
Maryland	should be ind Mental marked o	To Be	Albert Frank	Medura			Evely				
	1 and 2 sh Health and em 27 Is m ther traum		19a. Informant's Name/Relationship (Type RUSSETT S. MaiseT 20a. Method of Disposition	(spouse)	919 1	Berwick [	rive.	Annapolis,	MD 21	1403	
altimore,	permit. Pages Department of t Important: If ite any injury or of		1 XBurial 2 ☐ Cremation 3 ☐ Rei '4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Fue al Service License		emont (	sition (Name of natory or other place Cemetery . Name and Addre	4/	22/05	Davids	on - City or Tow	e Maryland Home, P.A.
<u>~</u>	Depril Impo		Dud. So	7 ()	3	3111 Moun	itain R	oad, Pasac	lena, M		
	Enysician		23a. Part1. Enter the disease, or complica shock, or heart failure. List only one Immediate Cause (Final disease or condition	ations that eaused the death		. 1	g, such as car	rdiac or respiratory ar	rest,		Approximate Interval Between Onset and Death
8760,	Medical Examiner  bhysician and the burial-transit	dicai Examiner	resulting in death)  Secuentially list conditions of any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  d.	Due to (or as a consequence to (or a) consequence to (or a) consequence to (or a) consequence to (or a) consequence to (or a)	USE uence of):	white	e m	atter	ischa	miq	your
O. Box 6	The law requires that the death certifica Ite has been signed by the attending ph bage 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 TaNo 9 □ Unknown	t. If yes, outcome of pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of do 9 □ Unknown	Ideath 3	Ectopic pregnancy Other (specify)	,			Date of delivery Month E	y Day Year
rds, P	quires that n signed b uld be deta	by	Part II. Other significant conditions contr	ibuting to death but not resi	ulting in the un	derlying cause grv	en in Part I.	23e. Did to			cause of death?
Il Records,		Completed						24a. Was autop pentor 1 ☐ Yes		prior to comp death?	sy findings available pletion of cause of
Vital	ysicien: Th is certificate director, pag	o Be	25. Was case referred to medical examiner?  1 \( \subseteq \text{Yes} \) 2 \( \subseteq \text{No} \)	spital:	ER/Outpatient	3□ DOA Oth		Death (Check only only only only Home 5 Resid		W /O - '/'	
ion of	ding Ph J. After th funeral	$\vdash$	27. Manner of Death  1  Natural 5  Pending 2  Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injun Work	v at	28d. Describe h			
Division	To the Hospitel or Attent within 24 hours after deatl To the Funerel Director: completely filled in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	ome, farm, stre	et, factory, office		28f. Location (S City or Tow	itreet and Nur n, State)	nber or Rural I	Route Number,
	To the Hospitel or #within 24 hours after To the Funerel Directon plate in birecton plate in birecton pletely filled in birecton pletely filled in birecton pletely filled in birecton pletely filled in birecton plate in birecton	edicai	29a. Certifier 1 Certifying Physic (Check only one) 2 Medical Examine	cian: To the best of my kno r: On the basis of examinal and manner stated.	wledge, death tion and/or inv	occurred at the tin estigation, in my o	ne, date and p pinion, death o	lace, and due to the occurred at the time, o	ause(s) and i	nanner as stat e, and due to t	led. he cause(s)
	To the I within 2 To the I complet	Me	29b. Signature and title of certifier	Ster Um	190m	29c. Licenso	e number	20 /	29d. Date sign	ned (Month, Da	ay, Year)
	/		30. Name and address of person who com	pleted cause of death (Item	23a) (Type, F	Print) Thou	1028 1025	Brushes	T/ 19/ rs - H	25 ~va	MD ALL
	り Sta	0	6501 N, Charle 31. Date filed (Month, Day, Year)	5 5T Ba	. Ivin		MD	212	85		
	Registr		APR 2 2 2005	37 Registrar's Signa	x Apr	de					

Please Type or Print in Black Indelible Ink.	. Ensure All Copies Are Legibl
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				1 - State of Mar Registrar Amend Items 29c,d, pe	yland/D r Dr.,	epartment of Certificate of	Health and M	ental Hygic	ene 0	05	13706
		Physic	ian	1. Decedent's Name (First, Middle, Last)				2. Date of Death Month	Day	Year	3. Time of Death
		/Medi		BARBARA R.		MOSHMAN		April	17	2005	06:35 AM
7	7	Examir	ner	4a. Facility Name (If not institution, give street and number) Sinai Hospital of Balt	imore		or Location of Death		4c. Count	of Death	N / 0
pshman		Funeral			In yrs. last birti	hday) If Under 1 Year	MOLL UH	8. Date of Birth	AAAA	9 Birthn	N/A
2		Director		057-09-8514 1□ M 2 X F		rs. Months Days	Hours Min.	8. Date of Birth JAN. 16,	<b>19</b> 17	Coun	lace (State or Foreign try)
3		pu *		Usual Residence of Decedent           10a. State         10b. County         1	10- O- T-						
5		Aarylan f show	5		I0c. City, Town					10	0d. Inside City Limits 1
X		the Mary 28a-f sh notified	Director	MD N/A  10e. Street and Number	D/	ALTIMORE 10f. Zip Code	· · · · · · · · · · · · · · · · · · ·	100	g. Citizen of	What Cours	
R		23a or		2500 W. BELVEDERE AVENUE #	<sup>4</sup> 512	10.124	21215	, , ,	9. 012017 01	Wilat Oouli	USA
3		ams	Funeral	11. Marital Status  12. Was Decedent Evindred Forces?  1 Never Married 2 Married 1 Yes 2 No	er in U.S.	13. Was Decedent of If Yes, specify Cub		cify Yes or No-		e - America	an Indian,
3	36	s afte	by Fu	If Yes, Give		1 ☐ Yes 2 🛣 No		iloan, etc.)	Specif	ck, White, e	
Barbara	5-0036	72 hours natural'	ed b	3 X Widowed 4 □ Divorced Year or Dates:	16a	Decedent's Usual Occu	Ination	16	Sb. Kind of B		WHITE
	215	d within 72 hi pisne. r than "natu	plet	(Specify only highest grade completed)		(Give kind of work done life. DO NOT use retire	during most of workir	ng lie	ob. Kind of B	usiness/ind	ustry
B	7	filed within 72 hours after death with the Maryland Hygiene. uther than "natural", or Itams 23a or 28a-f show inthe thanklical Examinar must be notified at	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	L	EGAL SECRET	ARY				LEGAL
5	pu	be do do	Be	17. Father's Name (First, Middle, Last)			18. Mother's Name		aiden Suman	ne)	
known	Maryland	d 2 should be th and Mental t7 is markad o traumatic eve	To	YEHUDA  19a. Informant's Name/Relationship (Type, Print)		GINSKY	MAYTATZ		2: **		(UNKNOWN)
\$		ロモトコ		SETH MOSHMAN / SON		Mailing Address (Street B13 BANEBER					
	Jre,	- F 5 5		20a. Method of Disposition	20b. Place of	Disposition (Name of crematory or other pla	D		c. Location		
2	<u>E</u>	Pages nent of I ant: If itu		1 🛱 Burial 2 ☐ Cremation 3 ☐ Removal from State  1 ☐ Donation 5 ☐ Other (Specify)		AHAVAS CHE		/2005	RAN	DALLS	TOWN, MD
Patient	Baltimore,	permit. Page Department of Important: If any injury of		21. Signature of Funeral Service Licensee		22. Name and Addre		LEVINSO			
og		0.0 ± a o		Edward (, KM)		8900 REIS	TERSTOWN R	OAD - PI	KESVI	LLE, N	MD 21208
				23a. Part1. Enter the disease, or complications that caused th shock, or heart failure. List only one cause on each line. Immediate Cause (Final		Λ	4	respiratory arrest	t,		Approximate Interval Between Onset and Death
		Physician / /Medical	92	disease or condition resulting in death)		cular a	cudent				
		Examiner		Due to (or as a c	consequence of	1):					
		p =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	onsequence of	f):					
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	9	tificate ng phys as the	edic	d							
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	D. E	The law requires that the death certific ate has been signed by the attending p page 2 should be detached for use as	Completed by Physician/Me	in the past 12 months?  1 ☐ Yes 2 ☑ No 4 ☐ Pregnant at tim 9 ☐ Unknown 9 ☐ Unknown		5 Other (specify)			Mo	nth [	Day Year
	Ρ.	that the	Phy	Part II. Other significant conditions contributing to death but n	not resulting in	the underlying cause give	ven in Part I	23e Did tohac	CO USA CON	ribute to the	cause of death?
	Division of Vital Records, P.O.	law requires that as been signed t 2 should be deta	d by			and and anything bedood give	voir in r dici.				bly 4 Dunknown
	COI	s beer	olete					24a. Was an	24b. \	Vere auton	sy findings available
	Re	The lav	omb					autopsy	d? 6	rior to com leath?	pletion of cause of
9	ita	sian: artifica ctor, p	BeC	25. Was case referred to medical examiner?			26. Place of Death	1 □ Yes 2 反 (Check only one)	a NO	☐ Yes 2	® No
J	of \	hyai this c	2	1 ☐ Yes 2 ☑ No Hospital: 1 ☑ Inpatient	2 ER/Outp	ALIGHT JUDON	ner: 4 Nursing Hom				
3900c	no	ding I h. After funer	tion	27. Manner of Death  1 Manual 5 □ Pending (Month, Day You investigation)  2 □ Accident investigation	ea <i>r)</i> 28b. Tir Inj	ury Wo	ry at 28 rk? Yes 2 □ No	3d. Describe how	injury occurr	ed	
7	<u> S</u>	Attanding Phyaician: r death. actor: After this certifics by the funeral director, p	fica	3 Suicide 6 Could not be	- At home, farn	m, street, factory, office		3f. Location (Stree	et and Numb	er or Rural	Route Number
* ,	Ö	s afte	Certification:	4 Homicide determined building, etc. (s	Specify)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		City or Town, S	State)		
		To the Hospital or Attanding Physician: The I within 24 Works after death. To the Funaral Diractor: After this certificate ha completely filled in by the funeral director, page		29a. Certifier (Check only one)  1 Certifying Physician: To the best of many one)  2 Medical Examiner: On the basis of example and many of the basis of example and m	ny knowledge,	death occurred at the tir	me, date and place, ar	nd due to the caus	se(s) and ma	nner as sta	ted.
		thin 2, tha P	Medical	one) and manner stated 29b. Signature and title of certifier	1.						
4		with To		K A Lamon MD		29c. Licens	5-000		Date signed Dril 1		
				30. Name and address of person who completed cause of death	h (Item 23a) (T			14	~**** T	,200	
	_			KAZI A. ZAMAN, MD	SINA		AL OF	BALTIM	ORE		
		Sta Registr	_	APR 2 2 2005	Signature	,					, ;
		riegisti	uı	THE WAY TOOL PROPERTY AS	STATE OF THE STATE						

State of Maryland / Department of Health and Mental Hygiene 1 - For State Ragistre Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Richard Reed Mister, Jr. 05 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 0 Baltimore Lare HOSDITA 5. Social Security Number If Under 24 Hrs. Hours Min. **Funeral** 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days 1XM 2□F Director Yrs 215-18-9215 92 Dec. 30, 1912 Maryland Usual Residence of Decedent the Maryland 10b. County 10a State 10c. City, Town or Location if item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director 1 ☐ Yes 2 No Maryland
10e. Street and Number Baltimore Dunda 1k 10f. Zip Code 10g. Citizen of What Country? 1607 Searles Road 21222 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Yes 2 ☒ No by Specify: Specify: White 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 2 should be filed within and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 years Layout Man Shipyard 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Richard R. Mister, Sr. Mamie E. Shores 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If Item 27 is any injury or other traus 7403 Belmont Avenue Richard R. Mister III (Son) Baltimore, Maryland 21224 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Dopation 5 ☐ 6 ther (Spegity) 2 Cremation 3 Removal from State Parkood Cemetery Apr. 21, 2005 Baltimore, Maryland And Service Vice san 21. Signiture of Fu 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Avenue Dundalk, Maryland 21222 Part Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line th. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** espirator resulting in death) /Medical as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury a consequence of) Examine burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) physician Box 68760 Physician/Medical use as the attending IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy þ in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. | the 9 Unknown 9 Unknown Š signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Be Completed by cate has been sig , page 2 should b 1 ☐ Yes 2 XNo 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? certificate Division of Vital 1 Yes 2. No Hospital or Attending Physician: funeral director 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 1 ☐ Yes 2 No Certification; To 1 ⊠1npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. 28d. Describe how injury occurred linjury at Work? After 1 Natural 5 Pending death. 1 Yes 2 No investigation 2 Accident after death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) á 4 T Homicide filled in 24 hours a Funeral C 29a. Certifiei 🔁 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal within 24 ho To the Fun completely f 2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

and manner stated. (Check only one) 29b. Signature and title of certifier 2 29d. Date signed (Month, Day, Year) D61761 address of person who completed cause of death (Item 23a) (Type, Print) ame an 9000 Franklin Square DRIVE Baltimore, MD 21237 0 32. Regierar's Signature 31. Date filed (Month, Day, Year) State 2005 Registrar

			For State	State of Maryland	•		ind Menta	al Hygien	е	
			1 - State Registrar		Certifi	cate of Death		Reg. N	0005	12700
	Physici	an	1. Decedent's Name (First, Middle, Last)	1 / 1/	1-1			te of Death	ay Year	8. Tinhe of Digith
	/Medic		4a. Facility Name (If not institution, give s	treet and number)	150N	City, Town or Location of	f Death	upri	22 2005 c. County of Death	7.30 AM
	Examin	er	Baltimore Rehobilit	to 8 to 1.10	PALE 6	attimor E	Death		c. County of Death	
	Funeral		5. Social Security Number 6. Sex			Jnder 1 Year   If Under 2	24 Hrs. 8. Dat	te of Birth	9. Birthp	lace (State or Foreign
	Director		219-18-3647 19	M 2□F 80	Yrs. Mo	nths Days Hours	Min. (Mc	onth, Day, Yea	4. MAR	YLAND
	and		Usual Residence of Decedent  10a. State 10b. County	10c. City.	Town or Locatio	n			1	0d. Inside City Limits
	Maryl f sho	ō	DA VOCK	,	Glen	Pack				1 ☐ Yes 2 XNo
	the	rec	10e. Street and Number		CICI	of. Zip Code		10g. C	citizen of What Coun	
	h with	ai Di	3445 Catholic	Valley Rd		1732	7		USA	•
	ams	Funeral Director	11. Marital Status	2. Was Deceden Ever in U.S. Armed Forces?	. 13. Was	Decedent of Hispanic Orig , specify Cuban, Mexican,	in? (Specify Ye	es or No-	14. Race - Americ Black, White,	
36	s afte		1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 PYes 2 □ No If Yes, Give		es 2 No Specify:	,	/	Specify: / . \	. ) .
21215-0036	filed within 72 hours after death with the Maryland Hygiene. the than "natural", or Itams 23a or 28a-f show the the Medical Evantum man be rediffed at	Completed by	15. Decedent's Educ	Year or Dates:	16a Decedent's	Usual Occupation		16h	Kind of Business/Inc	1 PC
212	in 72	piet	(Specify only highest grade Elementary/Şeçondary (0-12)	College (1-4or 5+)	(Give kind	of work done during most OT use retired)	of working	100.	Talle of Desiriossynic	austry
	ed with	Com	10	College (1-401 54)	ARMOT	RED CAR D	RIVER	- B	RINK'S	
Maryland	be file tal Hy d oth	Be (	17. Father's Name (First, Middle, Last)	. (-	·	18. Mother	's Name (First,	Middle, Maide	n Sumame)	
<u> </u>	should be nd Mental n marked c	To	Clmer C. 11	elson		(15	sie I	DACK		
Mai	d 2 sh th and 7 Is n traun		19a. Informant's Name/Relationship (Typ	les 1	19b. Mailing Ad	dress (Street and Number	1 21	Number, City	or Town, State, Zip	Code)
	1 and Health tem 27 other tr	1	20a. Method of Disposition	20b. Plac	ce of Disposition	(Name of	Date	(5) En	Location - City or To	wn, State
ē	Pages nent of int: If it		1 Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)	amoval from State	netery, cremator	0 1	1 21 -		4. n.	l is
Baltimore,	# 문문분		21. Signature of Funeral Service License	e Frank		ne and Address of Facility	·uu	-	ND 2123	54.
m	Depar Impo any ir	0 0	Kinberly 1. 3	Wrothy	EV.AN	S FUNELAL (			HARFORD	PD.
П			23a. Part1. Enter the disease, or complete shock, or heart failure. List only on	ations that caused the death.	Do not enter the					Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Alzhein	LEV'S	DISEASE				Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conseque	ince of):					
h	1 -	e	Sequentially list conditions, if any, leading to immediate	Due to (or as a conseque	nce of):					
	d d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events							
o,	ficate be executed physician and is the burial-transit	Exa	resulting in death) Last	Due to (or as a conseque	nce of):					
8760	ate bu	dicai	d.							
မှ	ding p	/Me	IF FEMALE:	3c. If yes, outcome of pregnance	**					
Box	death certific	Physician/Me	in the past 12 months?	1□Live birth 2□Fetal de 4□Pregnant at time of dea	eath 3 Ecto	pic pregnancy er (specify)			23d. Date of delive Month	ry Day Year
o.	the d	hysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown						
ď.	The law requires that the death certifite has been signed by the at ending tee hould be detached for use as	by PI	Part II. Other significant conditions conf	ributing to death but not resulti	ing in the underly	ring cause given in Part I.	23	e. Did tobacco	use contribute to th	e cause of death?
Records,	w require		Linking Treet	Infection	, D.	450/5 Me.	11:105	1 ☐ Yes 2	2 Mo 3 ☐ Proba	ably 4 Unknown
ecc	has be	piet	/	1	•		24	a. Was an autopsy	24b. Were autop	osy findings available
	The is	Completed					1	performed? Yes 2 N	death?	
Vital	ysicien: Th is certificate director, pag	Be	25. Was case referred to medical examiner?	ospital:			of Death (Chec	k only one)		
0	Phys rthis ral dir	. To	1 ☐ Yes 2 ☑ No 27. Manner of Death	1 Mainpatient 2 LEF	R/Outpatient 3( 8b. Time of	DOA Other: 4 Nur.		Residence	6 ☐Other (Specify	)
0	iding Phy th. : After thi s funeral (	tion	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	Work?		SCHOOL HOW HIT	ary occurred	
Division of	Atter ar dea ector by the	ertification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At hom- building, etc. (Specify)	e, farm, street, fa	actory, office	28f. Loc	ation (Street a	nd Number or Rural	Route Number,
ā	tal or rs afte al Dir ed in	Cert	4 _ Homede	Building, etc. (Specify)			City	or Town, Stai	(0)	
	To the Hospital or Attending Physicien: whim 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director.	edical	(Check only 2 Medical Examin	ician: To the best of my knowle er: On the basis of examination	edge, death occi n and/or investig	urred at the time, date and ation, in my opinion, death	place, and due	to the cause(se time, date ar	s) and manner as stand place, and due to	ated. the cause(s)
	thin 2 thin 2 or the	Med	29b. Signature and title of certifier	and manner stated.		29c. License number			ate signed (Month, L	
	F 3 F 8		11			_	6 (1	1	g.	
. ^	110		30. Name and address of person who cor	npleted cause of death (Item 2	3a) (Type, Print)	V 00156	18	a.f.	1 24,2	1
12	0	. 1	MARCOS GALÍC		00 loc	DO0156. LRAVENB	on/Evar	d, Bul	timerE Ma	21218
	Sta		31. Date filed (Month, Day, Year)	32 Registrar's Signatur	board	e e		/	,	<b>y</b>
	Registr	ar	AT N & & 200	Judgette 10						

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item I per me 8842 4-26-05 vt.

Physici /Medio		Registrar		Ce	ertificate of Death		g. No.	U.
	an	Decedent's Name (First, Middle,	ELLA ELLA			2. Date of Death Month	Day Year	
	cal	-Ella  4a. Facility Name (If not institution,	-în street and number!	Nealy	4b. City, Town, or Location of De	APRIL	18, 2005 5:16E	
Examir	ier		TREET		BALTIMORE	aui	NA	
uneral			5. Sex 7. Age	e (In yrs. last birthday	) If Under 1 Year   If Under 24 H Months Days Hours M	n. (Month, Day,	Year) 9. Birthplace (State of Country)	or Forei
irector		227–22–9673 Usual Residence of Decedent	1□ M 2\\ F	83 Yrs.		1-24-2	22 Vā	ì.
Mot		10a. State 10b. County		10c. City, Town or L		· · · · · · · · · · · · · · · · · · ·	10d. Inside C	
la-f st	ctor	Md. NA		Ba	ltimore		Yes	2 🗆 N
23a or 28a-f show	Director	10e. Street and Number			10f. Zip Code	10	g. Citizen of What Country? USA	
ns 238	Funerai	2404 E. Jeffer	12. Was Decedent 8	Ever in U.S. 13	21205 Was Decedent of Hispanic Origin?	(Specify Yes or No-	14. Race - American Indian,	
or Itan		1 ☐ Never Married 2 ☐ Marrie	Armed Forces? d 1 □ Yes 2 ☒ N		If Yes, specify Cuban, Mexican, Pu	erto Rican, etc.)	Black, White, etc.	
Ext.	d by	3 X Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 ☑ No Specify:		Specify: Black	
nati	lete	15. Decedent's (Specify only highest	Education grade completed)	(Giv	edent's Usual Occupation e kind of work done during most of v DO NOT use retired)	rorking 1	6b. Kind of Business/Industry	
than the M	Completed	Elementary/Secondary (0-12)  12th grade	College (1-4or 5	i+)	Medical Records		Baltimore City	
id other than "natural", or itams event, it's Mudical Extenination	Bec	17. Father's Name (First, Middle, La	ast)	,		ame (First, Middle, M	laiden Sumame)	
is markad aumatic ev	2	William		Walker				
itam 27 is marka othar traumatic		19a. Informant's Name/Relationshi	g (Type, Print) Brother		ling Address <i>(Street and Number or</i> 78 Tifton Ct., Ri			
itam 27 i		20a. Method of Disposition	DLOCHEL	20b. Place of Disc	position (Name of		a. 23224  Oc. Location - City or Town, State	
Important: If its any Injury or ot once.		1 XBurial 2 ☐ Cremation 3 14 ☐ Donation 5 ☐ Other (Spe			ematory or other place) cmel Cem. 4-2	1-05	Dundalk, Md.	
mporta any Inju		21. Signature of Funeral Service Li	censee	2	22. Name and Address of Facility	Baltimo	ore, Md. 21202	
트등점		Junt Co	g		March F.H. East nter the mode of dying, such as card		. North Ave.	
÷	Examiner	if any, leading to immediate	b. Due to (or as	a consequence of):				
nysician and he burial-tran:		Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a	a consequence of):				
/ the attending physician and ched for use as the burial-transit	edicai	mat initiated events	d23c. If yes, outcome	of pregnancy 2 □ Fetal death 3	□Ectopic pregnancy □ Other ( <i>specify</i> )		23d. Date of delivery  Month Day	Year
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Director: After this certificate has been signed by the attending in by the funeral director, page 2 should be detached for use as	To Be Completed by Physician/Medical	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1	d.  23c. If yes, outcome 1	of pregnancy 2   Fetal death 3 time of death 5  ut not resulting in the 2   O   O   O   O    ut not resulting in the 2   O   O   O    provided the control of the control o	underlying cause given in Part I.  26. Place of D  ont 3 DOA  Other: 4 Nursing of 28c. Injury at Work?  M 1 Yes 2 No  treet, factory, office  ath occurred at the time, date and planyestigation, in my opinion, death occurred at the time, date and planyestigation, in my opinion, death occurred at the time, date and planyestigation, in my opinion, death occurred at the time, date and planyestigation, in my opinion, death occurred at the time, date and planyestigation, in my opinion, death occurred at the time, date and planyestigation, in my opinion, death occurred at the time, date and planyestigation, in my opinion, death occurred at the time, date and planyestigation, in my opinion, death occurred at the time, date and planyestigation, in my opinion, death occurred at the time, date and planyestigation, in my opinion, death occurred at the time, date and planyestigation, in my opinion, death occurred at the time, date and planyestigation, in my opinion, death occurred at the time, date and planyestigation, in my opinion, death occurred at the time, date and planyestigation, in my opinion, death occurred at the time, date and planyestigation, in my opinion, death occurred at the time, date and planyestigation, in my opinion, death occurred at the time, date and planyestigation, in my opinion, death occurred at the time, date and planyestigation, in my opinion, death occurred at the time, date and planyestigation, in my opinion, death occurred at the time, date and planyestigation, in my opinion, death occurred at the time, date and planyestigation, and the time, date and planyestigation, and the time, date and planyestigation, and the time, date and planyestigation, and the time, date and planyestigation, and the time, date and the time, date and the time, date and the time, date and the time, date and the time, date and the time, date and the time, date and the time, date and the time, date and the time, date and the time, date and the time, date and the time, date and the time, date and the time, date and the	24a. Was an autopsy perform  1	Month Day  Acco use contribute to the cause of description of the completion of comple	death? Inknov availat ause o
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			State of Maryland / State Registrer	Department of Health and M Certificate of Death		4000 13711
			Decedent's Name (First, Middle, Last)	Continuate of Death	Reg. I	No.  3. Time of Death
	Physici		Dorothy M. Obringer	•		Pay Year 8 05 1350 M
}	/Medic Examir		4a. Fecility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
1	LAdimi	iei	Mercy Medical Center	Baltimore, A	CIN	N/A
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last b	irthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	9 Birthplace (State or Foreign
	Director		219-20-6926 1□M 2XXF 86	Yrs. Months Days Hours Min.	(Month, Day, Yea	
	p ,		Usual Residence of Decedent  10a. State 10b. County 10c. City. To			-
	show	2	10a. State 10b. County 10c. City, Total	wn or Location		10d. Inside City Limits
	Ne M	Director		dalk	1.2	1 □ Yes 2√3No
	with t		10e. Street and Number	10f. Zip Code	10g. (	Citizen of What Country?
	s 23	Funerai	27 Seabright Avenue  11. Marital Status 12. Was Decedent Ever in U.S.	21222		ited States  14. Race - American Indian,
	ter d	Š	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Never Married 2 □ Married  11. Yes 2 □ ▼No	<ol> <li>Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto</li> </ol>	Rican, etc.)	Black, White, etc.
38	ours after death with the Maryla ral', or Hems 23a or 28e-1 shov Examinat must be molified at	by	3 XWidowed 4 □ Divorced Year or Dates:	1 ☐ Yes 2 🔀 No Specify:		Specify: White
9	72 hours after death with the Maryland Instural, or flems 23a or 28e-f show diest Exendrat must be notified at			a. Decedent's Usual Occupation	16b.	Kind of Business/Industry
215	within 7 ene. than "n re Med	pje	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	(Give kind of work done during most of work life. DO NOT use retired)	ing	
21	filed with Hygiene. other than	Completed		ecretary-Bethlehem St	eel S	teel
pu	al Hygie d other	Be (	17. Father's Name (First, Middle, Last)	18. Mother's Name	e (First, Middle, Maid	en Sumame)
yla	should be find Mental be marked of	2	Alfred B. Woodhead	Lillie	Peters	
Maryland 21215-0036	2 should be and Mental is marked traumatic ev			b. Mailing Address (Street and Number or Rura		
	s 1 and 2 should be filed within 72 hours of Health and Mental Hygiene. Item 27 Is marked other than "natural", other traumatic event, Ira Medical Exp		Alfred B. Woodhead III (Nephew)	342 Golf View Drive	-	Georgia 30710
ore	Pages 1 nent of H ant: If ite ary or oth		20a. Method of Disposition 1	ery, crematory or other place)		Location - City or Town, State
Ë	. Pag tment tent: jury		`4 Donation 5 Other (Specify) Oak	Lawn Cemetery 4/21/	'2005 Ba	ltimore, Maryland
Baltimore,	permit. Pages 1 and Department of Health Importent: If item 27 any injury or other to once.		21. Signature of Funeral Service Licenson	22. Name and Address of Facility	Here wif Fa	andalk Inc
	707 e 0		Calle	Duda-Ruck Fureral 7922 Wise Avenue	Dundalk, I	Maryland 21222
K			23a. Part1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.	onot enter the mode of dying, such as cardiac o	or respiratory arrest,	Approximate Interval Between Onset and Death
3	Physician	2.0	Immediate Cause (Final disease or condition resulting in death)	ortic Stenosis		Chisel and Dealin
	/Medical Examiner		Due to (or as a consequence	e of):		
		-	Sequentially list conditions, if any, leading to immediate  b. Volume  Due to (or as a consequence	ver load		
	nted nsit	Examiner	cause. Enter Underlying Cause (Disease or injury	,		
,	n and ial-tra	Exa	that initiated events c. Due to (or as a consequence	of):		
8760,	death certificate be executed e attending physician and nd for use as the burial-transit	dicai	d			
9	ifficat g ph) as th	ledi				
Вох	leath certifica attending ph I for use as th	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal deat	h 3 Ectopic pregnancy		23d. Date of delivery
	deat	icis	in the past 12 months?  1  Yes 2 No 9 Unknown	5 Other (specify)		Month Day Year
P.0	that the de led by the a detached	hy	9 Unknown			
Ś	90	by 6	Part II. Other significant conditions contributing to death but not resulting	in the underlying cause given in Part I.		o use contribute to the cause of death?
ord	w requir been si should l		Coronary Artery disease		1 Tes	2 No 3 Probably 4 Unknown
e C	law r as be 2 sh	pje	Chronic Obstructive Pul	minary discoix	24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
of Vital Record		Completed		3	performed? 1 ☐ Yes 2 🕱 N	death?
/ita	Physician: Th this certificate ral director, pag	Be (	25. Was case referred to medical examiner?	26. Place of Death	Check only one	
7	Physi this c al dire	၉	1 ☐ Yes 2 No Hospital: 1 Inpatient 2 ☐ ER/O		me 5 Residence	6 ☐Other (Specify)
	D 9 6	ino in	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day Year) 28b.	Injury Work?	28d. Describe how in	jury occurred
Sio	Attanding it death. actor: After by the fune	cat	2 Accident investigation 3 Suicide 6 Could not be	M 1 Yes 2 No		
Division	7 9 7 -	Certification:	3 Suicide 4 Homicide  Solid not be determined  28e. Place of Injury - At home, for building, etc. (Specify)	arm, street, factory, office	City or Town, Sta	and Number or Rural Route Number, ate)
_	pitel		29a. Certifier 128 Certifying Physician: To the best of my knowledge	Is death projured at the time date and place	and due to the sever	/s) and annual so shad
	24 hos Prun Fun etely	ledical	(Check only one)    Check only one)    Check only one)   Check one)   Check one)   Check one)   Check one)   Check one)   Check one)   Check one)   Check one)   Check one)   Check one)   Check one)   Check one)	nd/or investigation, in my opinion, death occurr	ed at the time, date a	ind place, and due to the cause(s)
	To the Hospitel or within 24 hours after To the Funeral Dir. completely filled in I.	Me	29b. Signature and title of certifier	29c. License number	29d. C	Date signed (Month, Day, Year)
		2	Ill Gudusko MD	P18576	4	118/2005
. /	27		30. Name and address of person who completed cause of death (Item 23a)	(Type, Print)	1	110   2005
16			201 Sount David St Boll	100000 110 21200		
	Sta	ite	31. Date filed (Month, Day, Year) 32. Registrar Signature	& Aprile		
	Registr	ar	APR 2 2 2005 Massa	N. Popular		

	amend item#/, perfH, G842, 4/22 State of Maryland	ack Indelible Ink. Ensure All	Copies Are Legible.
	1 - State Registrar	Certificate of Death	Reg. No.
Physician /Medical	21-140 111-6-11	Polley	2. Date of Death Month Day Year APRIL 20 2005 11 AM
Examiner	UNIVESS, ty of Maryland Medical Medical	al CH Baltin or e	4c. County of Death
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. Ia:	st birthday) If Under 1 Year If Under 24 Hrs.  Yrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country)
illed within 72 hours after death with the Maryland Hygiene.  ther than "natural", or items 23a or 28a-1 show ant, the Medical Evanting figure to notified at any completed by Funeral Director	10a. State 10b. County 10c. City,	Town or Location Dalting	10d. Inside City Limits
affer death with the Mar or Items 23a or 28a-1sh in refined to the first lifts Funeral Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
ns 23a	11. Marital Status 12. Was Decedent Ever in U.S.	. 13. Was Decedent of Hispanic Origin? (Specif Yes, specify Cuban, Mexican, Puerto R	ify Yes or No- 14. Race - American Indian,
Francisco Evandose I by Fun	3 Widowed 4 Divorced Year or Dates:	If Yes, specify Cuban, Mexican, Puerto R  1 ☐ Yes 2 ☑ No Specify:	ican, etc.)  Black, White, etc.  Specify: Black.
ygiene, Per than "natura t, the Medical E	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  N - A	16b. Kind of Business/Industry  N - A
Mental Hygiene, arked other than attc event, then To Be Com	17. Father's Name (First, Middle, Last)		First, Middle, Maiden Sumame)  1 D. Nea (
Health and Health and Item 27 Is mutout traum	19a. Informant's Name/Relationship (Type, Pri 1)  Rdel O. Folley-father.  20a. Method of Disposition  1 A Burial 2 Cremation 3 Removal from State	19b. Mailing Address (Street and Number or Rural ce of Disposition (Name of Danetery, crematory or other place)	BALTIMORE MD 21234 te 20c. Location - City or Town, State
Department of Important: If it any injury or once.	'4 □Donation 5 □ Other (Specify)  21. Signature, of Funeral Service Lipensee	dens of Faith Com! 4-20	2-05 Nosedale MD TIMBRE, MD 21234
Departr Imports any inju	Kymberly Jackey	EVANS FUNERAL CHAPE	EL 8800 HARFORD RD.
be executed burial-transit burial-transit burial-transit al Examiner	23a. Part I. Enter the disease, or cooplications that caused the death. shock, or heart failule. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	orrhagic hydrence of):	interval Batween Onset and Death Smorth
S Cia		nce ot):	
igned by the attending physisted described for use as the by Physician/Medical	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown  23c. If yes, outcome of pregnant 1 Live birth 2 Fetal did 4 Pregnant at time of dea 9 Unknown	eath 3 DEctopic pregnancy	23d. Date of delivery  Month Day Year
been signed be should be detailed by Pleter by		ing in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?  1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown
cate has been signe, page 2 should be c			24a. Was an autopsy performed?  1 Yes 2 No 1 Yes 2 No 1 No 2 No 2 No 2 No 2 No 2 No 2 No
s certifi director	25. Was case referred to medical examiner?  1 \[ \gamma \text{ Yes} = 2 \lambda \] No  Hospital: 1 \[ \sqrt{Impatient} = 2 \[ \sqrt{EF} \]	26. Place of Death (  VOutpatient 3 □ DOA Cther: 4 □ Nursing Home	Check only one)  ⇒ 5 ☐ Residence 6 ☐ Other (Specify)
within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.  Medical Certification: To Be Compl			d. Describe how injury occurred
rs after death.  al Director: After the in by the funera  Certification:	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At hom building, etc. (Specify)		f. Location (Street and Number or Rural Route Number, City or Town, State)
in 24 hou he Funer pletely fill edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowle (Check only one) 2 Medical Examiner: On the basis of examination and manner stated.	edge, death occurred at the time, date and place, an n and/or investigation, in my opinion, death occurred	d due to the cause(s) and manner as stated. at the time, date and place, and due to the cause(s)
within 24 hours a To the Funeral I completely filled Medical Ce	29b. Signardre and title of certifier  Nonatologic	29c. License number  V 7 4 9 17-5	29d. Date signed (Month, Day, Year) 4/20/2025
_	3 Name and address of the short	125 Green St, 7	Baltimore MD 21201
State Registrar	31. Date filed (Month, Day, Year) 32. Registrar's Signatur  APR 2 2 2005	f sperti	
H 17 Rev 1/2001	A TO THE STATE OF		may the state At

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene

	1-	State Registrar		Certifica	ite of Death	Reg	J. No. () ()	1 0 00 1 00
		Decedent's Name (First, Middle,	Last)			2. Date of Death _Month	Day Year	3. Time of Death
Physician /Medical		Linda (	E. rastoo	c - Tutor		April	20 2005	1:53P.M
Examiner		Facility Name (If not institution, g		4b. Cit	y, Town, or Location of Deat	th	4c. County of Deatl	1
		Gilchrist	Center	1511-0	100500		BALTIM	
Funeral Director	_	1	7. Age (In yrs	s. last birthday) If Und Month:	er 1 Year   If Under 24 Hrs s Days Hours Min.		(ear) 9. Birth	nplace (State or Foreign
rector	Usi	ual Residence of Decedent		3/		19-3-4	47 MA	RÁTHOD
show at at	108	a. State 10b. County	10c. C	City, Town or Location				10d. Inside City Limits
Executive must be notified at by Funeral Director	1	MD		BALTI	more		i	1⊠Yes 2□No
inermatternatified	106	. Street and Number			ip Code	10	g. Citizen of What Co	untry?
ust b	Ó	622 Creigh	iton Ave.		21234.		USA	
nue	11.	Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13. Was Dec	edent of Hispanic Origin? (Specify Cuban, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - Amer Black, White	
by Fi		1 ☐ Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced	d 1 □ Yes 2 No If Yes, Give Year or Dates:	1 ☐ Yes	2 No Specify:		Specify:	ido
edt	-	15. Decedent's		16a. Decedent's Us	ual Occupation	11	6b. Kind of Business/l	ndustry
t, the Medical Is	<u> </u>	(Specify only highest	grade completed)	(Give kind of v	vork done during most of wa	rking		
o m	'	Elementary/Secondary (0-12)	College (1-4or 5+)	Health	Care Wor	Ker	Hospita	_(
event, the Mudical Be Completed		Father's Name (First, Middle, La	ast)	•	18. Mother's Na	me (First, Middle, Ma	aiden Sumame)	
aumatic event, tre M. To Be Comp	9	richard Jol	hn Blose		Elizak	neth M	ae Jos	ias
ac ac	19	a. Informant's Name/Relationship	p (Type, Print)	19b. Mailing Addre	ss (Street and Number or R	ural Route Number,	City or Town, State, Z	ip Code)
other traumatic		lames Harold	lutor		reighton H		And the second second	nd 21234
٥ ٥		a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3	3 □Removal from State	Place of Disposition (N cemetery, crematory of	other place)		Oc. Location - City or	
any injury or of once.		4 Donation 5 Other (Spe	ecify) EVA	INSFUNERAL	CHAPEL - 4 -	21-05 1	rorest H	II MI
any ir	21	. Signature of Funeral Service Lie	densee	22. Name	and Address of Facility 23	25 YORKRD	TIMONIU	n mb 2107
	23	ta Parti Enter the disease or or	omplications that care of the de-	YEACE F	ULALTERIVATI	or respiratory arres	il Chape (C	
		a. Part1. Enter the disease, or co shock, or hear failure. Let or mediate Cause (Food	nly one cause on each line.	ani. Do not onto the m	odo or dying, suom da odraid	o or respiratory arres		Approximate Interval Between Onset and Death
ian ical	dis	sease or condition sulting in death)	a. CUNG	CANCE				Months
ner		1	Due to (or as a conse	equence of):				
e le	Se	quentially list conditions, any, leading to immediate use. Enter Underlying use (Disease or injury	b. Due to (or as a const	equenes of):				
Examiner	Ca	use. Enter Underlying use (Disease or injury at initiated events	c=					
xar								
		sulting in death) Last	Due to (or as a conse	equence of):				
he bur			Due to (or as a conse	equence of):				
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ding physicia a as the bu	IF	FEMALE:  b. Was decedent pregnant in the past 12 menths?	d	nancy tal death 3 ⊟Ectopic			23d. Date of deli	very Day Year
ding physicia a as the bu	IF	sulting in death) Last FEMALE:	d	nancy tal death 3 ⊟Ectopic				
ding physicia a as the bu	IF	FEMALE: b. Was decedent pregnant in the past 12 menths? 1 \( \sqrt{9}\) Yes 2 \( \sqrt{2}\) No	d. 23c. If yes, outcome of preg. 1 Live birth 2 Fe 4 Pregnant at time of 9 Unknown	nancy tal death 3 ☐Ectopic death 5 ☐ Other (	specify)	23e. Did toba		Day Year
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	•	1 - For State Registrar	State of M						•	2 (	005	13713	
Physici	an								2. Date of De	ath Day	Year	3. Time of Death	
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Examin	er		./ / /	Acrel oc	7.	/	/	of Death					
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		217-34-9889	1 <b>X</b> M 2□ F	67 Yrs.	Months	Days	Hours	Min.	(Month, Da	v. Year)	PA	nplace (State or Foreign untry)	
		Usual Residence of Decedent											
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or Iter	표	1 Never Married 2 Marrie	1 □ Yes 2 🔀	No					Rican, etc.)				
ral', c	1 by	3 Widowed 4 Divorced	Year or Dates:		1 Li Yes	2 <b>)</b> 2  No	Specify:			Spe	cify: Wh	ite	
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filed Hygie ther ther	ပ္		est)			. 01		er's Name	(First, Middle,	Maiden Sum	name)		
id be ental ked c	œ o	Antonio Pier	orazio				Δ11	rora	Patt	onni	,		
shou ind M mar umat	-			19b. Ma	iling Address	(Street a					wn, State, Zi	ip Code)	
and 2 alth a 27 is		Gerardo Pier	orazio	8	04 My	rth	Ave	. Ba	ltimo:	re MD	2122	21	
of He of He fiter		20a. Method of Disposition	□Removal from State	20b. Place of Dis cemetery, cr	position (Name	ne of ther plac	e)	Di	ate	20c. Locatio	on - City or T	own, State	
Pag ment ant: i				1					/05	Balt	imore	e MD	
permit. Depart Import any inj		21. Signature of Funeral Service Li	censee (	a lly				COL	nelly Baltim	Funer	alHor	meofEssex	
		23a. Part 1. Enter the disease, or co shock, or heart failure. List or	omplications that cause	the death. De not e	nter the mod	e of dyin	g, such as	cardiac or	respiratory ar	rest,		Approximate Interval Between	
		Immediate Cause (Final disease or condition	, D		Λ							Onset and Death	
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ysicia s cert direct	m	examiner? 1 ☐ Yes 2 🔀 No	Hospital:	ent 2 ER/Outpati	ent 3 DC	Othe	300				Other (Speci	ifv)	
g Ph		27. Manner of Death	28a. Date of Inju	ury 28b. Time		8c. Injury	at	-				,	
endir sath. or: Af he fu	atic	2 ☐ Accident investiga	tion		М			No					
or Att	ıti İ		28e. Place of In building, et	ury - At home, larm, : c. (Specify)	street, factory	, office		2			mber or Rui	ral Route Number,	
pital ours al		200 Cartifice 150 Cartifying	Physicians To the best	of my knowledge, do	ath accurred	at the time	a data ar	d elece e	ad due to the				
24 hos Prun etely i	dica	(Check only 2 Medical Ex	aminer: On the basis of	f examination and/or	investigation,	, in my of	oinion, dea	ith occurre	d at the time,	date and plac	manner as : e, and due i	stated. to the cause(s)	
To the within To the Somple	Me e	29b. Signature and title of certifier	1 1		290	. License	number			29d. Date sig	ned (Month,	Day, Year)	
0/		1 Sam	1-1		K	ES	001	000		4-19	3-05	•	
1		30. Name and address of person w	no completed cause of	leath (Item 23a) (Typ	e, Print)	_		1	/ >				
/		- 1 - 701111 - 01 01		) Franklin.	Square	e Di	ive	Bal.	timore,	Md. L	123	7	
Sta	ite ar	100		Signature	. /	w .							
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Hospital or Attending Physician: The law requires that the death with the Maryland or Sear show and Manial Hygiene.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit or page.	After this certificate based signed by the attending physician and functions. To Be Completed by Physician/Medical Examiner.	Physician / Medical Examiner  Funeral Director	Physician / Medical Examiner  Funeral Director  Director   Second   Security Number   Second   Security Number   Securit	1 - State Registrar   Colored Registrar   Co	Physician / Indicated Examiner  Funding   Decoration   De	Physician   Anthony   Pierorazio   Anthony	1 - State   1 -	The State of Death Personal Security Number (First, Modes, Last)  Anthony Pierorazio  Anthony Pierorazio  Anthony Pierorazio  A Facility Name (first Address, plan area and number)  Francision (Control of Security Number (First, Modes, Last)  Fundal Director (Control of Security Number (Control of Security Num	Topicion   Topicion	1	1- Support of the Control of the Con	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No.-1 Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Sherry Peele 4,2005 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death **Examiner** Dal General Date of Birth (Month, Day, Year Birthplace (State or Foreign Country)

Md If Under 1 Year If Under 24 Hrs. Hours Min. Age (In yrs. last birthday, Social Security Number 6. Sex **Funeral** Davs Months 1 □ M 2√ □ F Director 60 Dec 8, 1944 Unknown Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State 28a-f show item 27 is marked other than "neturet", or itams 23s or 28a-f show other traumatic event, it woulds! 1 Yes 2 No N/A Baltimore Director Md 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21217 U.S.A. 1701 Eutaw Place Completed by Funeral iled within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S Armed Forces? Black, White, etc. 1 □Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🕱 No Specify: Black Specify 3 Widowed 4 Projvorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. St. Vincent DePaul Society Elementary/Secondary (0-12) College (1-4or 5+) Assistant 12 18. Mother's Name (First, Middle, Maiden Surname) land 17. Father's Name (First, Middle, Last) Be h and Mental + ed bluods Lestina Boyer Richard L. Booth 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1 and 2 815 Winters Lane Catonsville, Md 21228 If of Health Lestina Boyer Mother Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 X Buriai 2 ☐ Cremation 3 ☐ Removal from State injury or Department of Important: If eny injury or once. 04/26/05 Baltimore, Md 4 ☐ Donation 5 ☐ Other (Specify) Western Cemetery 21. Signatur of Foneral Service Licenses 22. Name and Address of Facility Estep Brothers Funeral Service 1600 Eutaw Place Baltimore, Md 21217 23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one sause on each line. Approximate Interval Between Onset and Death the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physiclan/Medical Examiner burial-transit The law requires that the death certiticate be executed Due to (or as a consequence of): Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 3 Probably 44 Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy perform 2 No 1 Yes 2 No 1 Yes Hospitel or Attending Physicien: director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence Hospital: 2 ER/Outpatient 2 1 Yes 2 No 1 Inpatient 3□ DOA 6 ☐Other (Specify) funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27, Manner of Death 28b. Time of Certification: 5 Pending investigation 1 Natural s after dec. 2 No М 1 Tyes 2 Accident Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined. 4 Homicide within 24 hours a To the Funerel I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

32. Registrate Signature

APR 2 2 2005

**ORIGINAL** 

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who completed cause of death (Item 23a) (T

			1 - For State Registrar	State of Ma	aryland / De	epartment of Certificate		and Mo		giene (	)5	13715									
	Physici /Medic		1. Decedent's Name (First, Middle, Michael	Pyle					2. Date of Dea Month	Day	Year OO 5	3. Time of Death									
	Examin	er	4a. Facility Name (If not institution, Sc.	cours		Ba	- /	0-0			y of Death										
	Funeral Director		5. Social Security Number 218–62–9863 Usual Residence of Decedent	6. Sex 7. Age  ★ M 2 F	e (In yrs. last birtho	Months   D	ear If Under	Min.	8. Date of Birt (Month, Da 2/19/	1954	9. Birth Cou Mar	place (State or Foreign intry) yland									
	Maryland f show ied at	or	10a. State 10b. County		10c. City, Town o							10d. Inside City Limits 1 XYes 2 ☐ No									
	with the I a or 28e- be notif	Direct	10e. Street and Number 2107 Christian	C+		10f. Zip Co	de 1223				What Cou	intry?									
036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "naturel", or items 23a or 28e-f show other traumatic event, the Madical Examinar must be notified at	by Funeral Director	11. Marital Status  **Never Married 2   Married 3   Widowed 4   Divorced	12. Was Decedent I	Ever in U.S.	13. Was Decedent If Yes, specify	of Hispanic Ori Cuban, Mexican	gin? (Spec n, Puerto F	cify Yes or No- Rican, etc.)	USA 14. Ra Bla Speci	ck, White	ican Indian, , etc. Nhite									
21215-0036	d within 72 ho giene. sr then "natur i the Medical.	Completed	15. Decedent (Specify only highest Elementary/Secondary (0·12)	s Education grade completed) College (1-4or 5 n/a	5+) (G	ecedent's Usual O ive kind of work d e. DO NOT use n	lone durina mosi	t of workin	g	16b. Kind of E	Business/Ir	,									
Maryland	should be filed within and Mental Hygiene. It marked other than umatic event, the M	To Be (	17. Father's Name (First, Middle, L Francis W. Pyle	•			18. Mothe		(First, Middle, th D. I	Maiden Suma Brooks	me)										
	1 and 2 sho Health and P em 27 Is ma other trauma		19a. Informant's Name/Relationsh Ronald Pyle - I		2	lailing Address (SI L23 Ramsa	ay St.,					p Code)									
Baltimore,	0 0		20a. Method of Disposition  1   Burial 2 □ Cremation  4 □ Donation 5 □ Other (Sp		20b. Place of Di cemetery, Meac Memoria	sposition (Name of crematory of other COWFICGE AT Park	of r place)		/2005	20c. Location	-										
Balti	permit. Pag Department Importent: I any injury o		21. Signature of Funeral Service L	icensee				Gar Corla	Y Larka			al Home at 21075									
	Pnysician		23a. Part1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final disease or condition	infy one cause on each lir	the death. Do not no.		f dying, such as $t \sim c e$		respiratory ar	rest,		Approximate Interval Between Onset and Death									
	/Medical Examiner		resulting in death)	- a.	a consequence of):																
8760, <	ate be executed hysician and the burial-transit	completed by Physician/Medical Examiner	by Physician/Medical	by Physician/Medical	Physician/Medical	by Physician/Medical						Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	a consequence of): a consequence of):							
Box 6	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit						IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 ∐Live birth 4 ∏ Pregnant at 9 ☐ Unknown	2 Fetal death	3 □Ectopic pregn 5 □ Other (specif				11.0	ate of deliv	ery Day Year					
rds, P.O.	quires that I n signed by uld be deta						by	by	by	by	by	Part II. Other significant condition	e underlying caus				d tobacco use contribute to the cause of death?		4.7		
I Records,	The ate his page						0					24a. Was autop perfor 1 Yes	sy med?	prior to co death?	opsy findings available impletion of cause of						
Vital	Physicien: this certific ral director,	To Be (	25. Was case referred to medical examiner?	I I a market.	e COU/		Othor		(Check only o	ne) lence 6 □Oti	nor (Space	fu)									
Division of	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.		27. Manner of Death Natural 5 Pending 2 Accident investig	28a. Date of Inju (Month, Day	ry 28b. Tim	e of 28c.	Injury at Work?	21		ow injury occur		,y)									
Divis	tei or Att rs after de el Directo ed in by t	Certification;	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi		ury - At home, farm c. (Specify)	, street, factory, of	fice	2	8f. Location (S City or Tow	Street and Num n, State)	ber or Run	al Route Number,									
	To the Hospitel or within 24 hours after within 24 hours after to the Funerel Direct completely filled in	edical	29a. Certifier Certifying (Check only one)	Physician: To the best of examiner: On the basis of and manner sta	f examination and/o	eath occurred at the investigation, in a	he time, date and my opinion, deat	d place, ar th occurre	nd due to the o d at the time, o	cause(s) and m date and place,	anner as s and due t	stated. o the cause(s)									
	with To 1	Σ	29b. Signature and title of certifier	/			cense number	100		29d. Date signe											
	7		30. Name and address of person v	2 1 2 12	eath (Item 23a) (Ty	pe, Print)	we Si	tiee -	+ Bal	tinue,	Mary	2005 land 21223									
	Sta Registr		31. Date filed (Month, Day, Year) APR 2 2	2005 32 Aegistra	ar's Signature	perti					<del>_</del>										

		For	State of Mary	rland / De	partment of H	lealth and N	•	_	13716	
		1 - State Registrar		<u> </u>	ertificate of	Death		g. No.	10/10	
Physic /Medi		1. Decedent's Name (First, Middle, Last)  AGATET	POLICA	5774			2. Date of Death Month	Day Year	3. Time of Death	
Exami		4a. Facility Name (If not institution, give s			4b. City, Town, o	Location of Death		4c. County of Dea	th	
		JOHNS HOPKINS B	AYVIEW ME	DICAL		IMORE		N/A		
Funeral Director		212-09-1064	7. Age (In	yrs. last birthde 5	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, SEPT.	9. Bir 3,1919 M	thplace (State or Foreign ountry) ARYLAND	
pue ≱ ;		Usual Residence of Decedent  10a. State 10b. County	10	c. City, Town or	Location				10d. Inside City Limits	
danyla f sho	0	MD. N/A		BALTI					1X Yes 2 □ No	
28a-	Funeral Director	10e. Street and Number		DAULT	10f. Zip Code		10	og. Citizen of What C	ountry?	
3a or	Ö	3828 FAIT AVEN	UE		21	224		U.S.A		
death	ner		12. Was Decedent Eve Armed Forces?	r in U.S. 1	Was Decedent of H     If Yes, specify Cuba		pecify Yes or No-	14. Race - Am Black, Whi	erican Indian,	
or ite		1 Never Married 2 Married	1 Yes 27 No		1 ☐ Yes ♣☐ No	Specify:	o 1110a11, 010.7	Specify:	10, 610.	
hours urai;	q p	3 ₹ Widowed 4 □ Divorced	Year or Dates:	1 10 0				ITE		
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with in with i	Completed by	Elementary/Secondary (0-12)	College (1-4or 5+)		SHIER	-/		RESTAURA	NΤ	
yiolity 212.12.00000 build be filed within 72 hours after death with the Maryland Mental Hygiene. arkad other then "natural", or Items 23a or 28a-1 show atto event, the Modical Examiner must be multiled at	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Nan	ne (First, Middle, M			
uld be Vlenta Vlenta rrkad	10 E	ANDREW F. AM'	TMANN			MARIE	ANTOIN	ETTE BUT	TERHOFF	
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C, IV		MARY A. WOOD/ DA							L, MD. 2105	
or of H		20a. Method of Disposition    X Burial 2   Cremation 3   F	removal moni State		sposition (Name of crematory or other place			20c. Location - City of		
t. Pa rtmen rtant: vjury		' 4 □ Donation 5 □ Other (Specify)		ST. ST					E, MARYLAND	
Datumore, permit. Pages 1 an Department of Heal Important: If Item 2 any injury or other		21. Signature of Funeral Service Licens	***	-111	LILLY &	ZEILER	INC. FU	NERAL HOLLTIMORE,	ME	
		23a. Part1. Enter the disease, or compl shock, or heart failure. List only or	ications that caused the	e death. Do not					Approximate	
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Physician /Medical		disease or condition resulting in death)	Due to (or as a co		ie Corma	- UAS	wear de	ندمي	year	
Examiner		Company and table that are additions								
P =	iner	if any, leading to immediate cause. Enter Underlying	Sequentially list conditions, if any, leading to immediate cause. Energy underlying Due to (or as a consequence of):							
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The law requires that the death certificate has been signed by the attending phyage 2 should be detached to use as it	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of p				,	23d. Date of de	elivery	
death deathe	Cia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1□Live birth 2 □ 4□Pregnant at tim		3 ☐ Ectopic pregnancy 5 ☐ Other (specify) _	/		Month	Day Year	
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alaw I	ompleted	doneuha					24a. Was ar autops	y prior to	utopsy findings available completion of cause of	
	S						perform 1 Tes 2		s 2 No	
ding Physician: 1 h. After this certificat funeral director, p.	o Be	25. Was case referred to medical examiner?	Hospital:		Ott		ath (Check only on			
P P P	H	1 ☐ Yes 2 ☐No ☐ 1 ☐ Yes 2 ☐ No ☐ 1 ☐ Yes 2 ☐ No ☐ 1 ☐ Yes 2 ☐ No ☐ 1 ☐ Yes 2 ☐ No ☐ 1 ☐ Yes 2 ☐ No ☐ 1 ☐ Yes 2 ☐ No ☐ 1 ☐ Yes 2 ☐ No ☐ 1 ☐ Yes 2 ☐ No ☐ 1 ☐ Yes 2 ☐ No ☐ Yes 2 ☐ No ☐ Yes 2 ☐ No ☐ Yes 2 ☐ No ☐ Yes 2 ☐ No ☐ Yes 2 ☐ No ☐ Yes 2 ☐ No ☐ Yes 2 ☐ No ☐ Yes 2 ☐ No ☐ Yes 2 ☐ No ☐ Yes 2 ☐ No ☐ Yes 2 ☐ No ☐ Yes 2 ☐ No ☐ Yes 2 ☐ No ☐ Yes 2 ☐ No ☐ Yes 2 ☐ No ☐ Yes 2 ☐ No ☐ Yes 2 ☐ Yes	1 Inpatient	28b. Tim			Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred			
oding th: Afte	atior	1 € Natural 5 □ Pending (Month, Day Year) Injury Work? 2 □ Accident investigation M 1 □ Yes 2 □ No								
OVISION  Or Attending after death.  Director: After in by the fune	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (	- At home, farm	, street, factory, office		28f. Location (St. City or Town	reet and Number or F	Rural Route Number,	
safe in a feet i			Danieli g, oto-, (							
To the Hospital or Attending within 24 hours after death. To the Funeral Director: After Agmplately filled in by the fune funeral precedure.	ledicai	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exemi	sicien: To the best of n iner: On the basis of ex and manner stated	amination and/o	eath occurred at the til or investigation, in my o	me, date and place opinion, death occu	e, and due to the ca urred at the time, da	ause(s) and manner a ate and place, and du	is stated. e to the cause(s)	
To the Young	Me	29b. Signature and title of certifier	476		29c. Licens	se number	29	9d. Date signed (Mor	th, Dey, Year)	
1//		Timeral Wise	nes)		DI	3667		19-21-20	cs	
51		30. Name and address of person who co	ompleted cause of deat	h (Item 23a) (Ty	pe, Print)			<b>&gt;</b>	1 -	
		Thickers Just Care	23 Pagistrada	Pitel	us Higuna	F 508 (	blen Bru	es ilangla	19012 101	
S <sup>i</sup> Regis	tate trar	31. Date filed (Month, Day, Year)	32. Registrar's	Signature	pe, Print)	a comment				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav Year **Physician** Month Ellen Poindexter 04/13/2005 1:30pm /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Potomac Valley Nursing Home Rockville Montgomery If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Social Security Number 309-48-2494 8. Date of Birth (Month, Day, Year) **Funeral** 1□M 2**%**F 90 Yrs Director May 7,1914 Odon, IN Usual Residence of Decedent filed withIn 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show ? is marked other than "natural", or Items 23a or 28a-f shot traumatic event, the Modical Explainer must be notified at MD Montgomery 1 Yes 2 No Rockville Directo 10e. Street and Number 1235 Potomac Valley Road 10f. Zip Code 10g. Citizen of What Country? 20850 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ★★ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2XXIo White Specify: Specify Be Completed by 3 XWidowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 12 Own Home Homemaker permit. Pages 1 and 2 should be filt Department of Health and Mental Hy Important: if Item 27 is marked oth any jinjury or other traumatic event 20x8: 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Chester Sommers Edna Herndon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Poindexter / Son 10 Barrington Fare, Rockville MD 20850 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Walnut Hill Cem. April 21, 2005 Odon, 21. Signature of Fun ral Service Licensee 22. Name and Address of Facility Charles L. Stevens Funeral Home Inc 1501 Fast Fort Ave Baltimore MD 21230 23a. Part. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Final **Physician** 140 Sepsi disease or condition resulting in death) 40 /Medical Due to (or as a consequence of): Examiner ement Sequentially list conditions, if any, leading to immediate Englished or injury that initiated as our injury Examiner Due to (or as a consequence of): or Attsnding Physician: The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last been signed by the attending physician and should be detached for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by gestive 1 Yes 2 No 3 Probably 4 Nnknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has page 2 autopsy performed? Yes 25 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation М 2 Accident the within 24 hours after death To the Funeral Director: 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) 29c. License number 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Research BLUD Sui AR 2401 31. Date filed (Month, B egistrar's Signature 32

State Registrar

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Year **Physician** Henry Edward Posko, Sr. 11:50 A.M. 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Glen Burnie North Arundel Hospital Anne Arundel 8. Date of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6 Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1⊠M 2□F 216-20-6571 Yrs. Director May 29,1928 Maryland Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f show 7 is marked other than "natural", or itame 23a or 28e-f shov treumatic event, the Modical Exp. ping it may be notified at 1 ☐ Yes 2 XNo Director Anne Arundel Pasadena Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21122 United States 303 Kent Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 □ No If Yes, Give Year or Dates: WWII 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 25 Married timore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: ģ permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. importent: If item 27 is marked other than "natural", any hjury or other treumatic event, Ite Medical Exp. once. 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) U.S. Military 8 Years Planner & Estimator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Henry John Posko Anna Zaworski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Theresa D. Posko (Wife) 303 Kent Avenue Pasadena, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State tX Burial 2 ☐ Cremation 3 ☐ Removal from State □Donation 5 □ Other (Specify) Stanislaus Cem. 4/18/2005 Baltimore, Maryland 21. Signa ve of Funeral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) owlmonom Pnysician /Medical Du to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate that the cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): the death certificate be executed as the burial-transit Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Tetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4 Pregnant at time of death 5 Other (specify) of Vital Records, P.O. detached 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Probably 4 □Unknown 1 ☐ Yes 2 ☐ No peeu 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) To Hospital: 1 Inpatient 1 Yes 2 No Other: 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred Division 5 Pending investigation 1 Natural 2 Accident after death.

I Director: After the furthe 1 ☐ Yes 2 ☐ No 6 Could not be 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 3 ☐ Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 | Homicide within 24 hours a 29a. Certifier 118 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier MD UW

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DHMH 17 Rev 1/2001

State Registrar

ORIGINAL

Drove

32. Registras Signature

Name and address of person who completed cause of death (Item 23a) (Type, Print)

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1-	For State Registrar
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			1 - State Registrar			Certifica	ate of	Death	44	R	leg. No.			
	Dhi.		1. Decedent's Name (First, Middle, La	•						2. Date of Dea	ıth	Voor	3. Time o	of Death
	Physici /Medi		<del>Lester Forrest</del>	<del>Rogers ·</del>	Lester	Fores	t Ro	ogers		April	28°, 200	5"	7:45	ам
	Examir		4a. Facility Name (If not institution, giv	e street and number)	)	4b. C	ty, Town,	or Location of I	Death		4c. County of			
			1012 Maple Road				sex	1 14 Hodos Od	Uso		Balti			
	Funeral Director		5. So 235 wit 18 ab 6 341 6. S 235-81-6341 Usual Residence of Decedent	ex 7. Ag	ge (In yrs. last bii 83	Yrs. If Un Monti	der 1 Year ns Days		Min.	B. Date of Birth (Month, Day Sept. 6	, Year) 1921	Count	virg	or Foreign inia
	/land		10a. State 10b. County	-	10c. City, Tow	n or Location						10	d. Inside C	City Limits
	Man Man	ţ	Maryland Baltimor	e	Essex	₹						İ	1 ☐ Yes	s 2 XNo
	or 28	Director	10e. Street and Number			10f.	Zip Code			1	10g. Citizen of W	nat Count	ry?	
	23a		1012 Maple Road				21221	1		,	U.S.A.			
	ar dez	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	?	13. Was De If Yes, s	cedent of pecify Cul	Hispanic Origin ban, Mexican, F	n? (Spec Puerto R	ify Yes or No- ican, etc.)		- America , White, e		
21215-0036	be filed within 72 hours after death with the Maryland tal Hygiene. d other than "netural", or items 23a or 28e-1 show event. Fro Medicul Erar is at must be trytified at	by	1 ☐ Never Married 2X Married 3 ☐ Widowed 4 ☐ Divorced	1 XXes 2 ☐ If Yes, Give Year or Dates:	No WWII	1 □ Yes	2 <b>∑</b> No	Specify:			Specify:	W)	hite	
2-0	72 ho	eted	15. Decedent's E	ducation	16a	. Decedent's U	sual Occu	ipation e during most o	if working		16b. Kind of Bus	iness/Ind	ustry	
2	within ene.	Completed	Elementary/Secondary (0-12)	College (1-4or		life. DO NO	use retire	ed)	" WOIKIN	1	_			
7	filed with Hygiene. Ither than		8 17. Father's Name (First, Middle, Last,	1	Pa	ainter	/ Cai	penter	Nama	(Eises Middle	Constru Maiden Sumame		<u>1</u>	
anc	ntal hed of	Be	Gruder Rogers					Gay 1			Maiden Surname	/		
Maryland	2 should be and Mental is marked o	2	19a. Informant's Name/Relationship (	Type, Print)	196	. Mailing Addr	ess (Stree				r, City or Town, S	itate Zin (	Code l	
Z	0 8 8		Bernice Rogers (W	•	1						aryland		-/	
re,			20a. Method of Disposition		20b. Place o	f Disposition (i		-	Da		20c. Location - C			
E	Pages nent of ant: If it		1 ☐ Burial 2 ☐ Cremation 3 ☐  '4 ☐ Donation 5 ☐ Other (Specif		Methia	s Menno	nite	Cem. 04	1/22/	2005	Methias,	Wes	t Vi	rginia
Baltimore,	permit. Page Department of Important: if any injury or once.		21. Signature of Euperal Service Licer	1588							l Home,	Р. Д.		
	80559		5		>	1407	Ola	Laster	n Av	enue, 1	Essex, M	aryıa		
			23a. Part. Enter the disease, or com shock, or heart failure. List only						rdiac or	respiratory arr	est,		Approxima Interval Be Onset and	etween
	Physician /Medical		Immediate Cause (Final disease or condition regulting in death)		elkepl		gel	ma					Direct and	5000
	Examiner			Due to (or as	a consequence	of):	•							
L,		er	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a consequence	of):								
	cuted id ansit	Examiner	Cause (Disease or injury that initiated events	G										
o,	e exection and an arrial-tr	Exa	resulting in death) Last	Due to (or as	a consequence	of):								
68760,	ate by hysicathe but	ledical		_ d					_					
Box 6	h certificate be executed ending physician and use as the burial-transit	$\leq$	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnancy 2 Petal death	3 □Ectopio	program	24			23d. Date	of deliver	y	
	The law requires that the death on the has been signed by the attendage 2 should be detached for users.	Physician	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant a 9□ Unknown		5 ☐ Other		-7			Mont	n E	Day	Year
P.0	that the de		Part II. Other significant conditions of	contributing to death t	out not resulting i	n the underlyin	n causa ni	iven in Part I		23a Did tol	bacco use contrib	ute to the	a cause of	death?
Records,	signe d be	d by		g			y y				es 2□No 3			
cor	w require been si should b	leted							_	24a. Was a	n 24h W	are auton	sy findings	available
Re	The tay ate has page 2	ompl			·					autops	med? pri	or to com ath?	pletion of d	cause of
Vital		e C	25. Was case referred to medical					26. Place of	f Death /	1 Yes 2 Check only on		Yes 2	2□ No	
<u> </u>	ys dilb	o B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1  Inpatio	ent 2 ER/Ou	utpatient 3	DOA O	thos		e 5 Reside	_	(Specify)		
n of		nc:	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Inju (Month, Da		Time of Injury	28c. Inju	iry at	28	d. Describe ho	ow injury occurred	ı		
Sio	death. ctor: A	catic	2 Accident investigation			М	1	Yes 2□No						
Division		Certification;	3 Suicide 6 Could not b 4 Homicide determined	286. Flace of III	jury - At home, fa tc. <i>(Specify)</i>	ım, street, fac	ory, office		28	If. Location (St City or Town	treet and Number n, State)	or Rural	Route Nun	nber,
	To the Hospitet or I within 24 hours after To the Funerel Direct completely filled in b	Medical C	29a. Certifier 1 Certifying Pt (Check only one) 2 Medical Exar	nysician: To the best niner: On the basis o and manner st	of examination an	e, death occurr nd/or investigat	ed at the ton, in my	ime, date and popinion, death	olace, an	d due to the call at the time, d	ause(s) and mani ate and place, an	ner as stat d due to t	ted. the cause(:	s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	1	1	4	9c. Licen	se number		2	9d. Date signed	Month, D.	ay, Year)	_
)	1	5	) Josep a	atthur	1	J.	20	955	)		4/2//	05		
6	H1-		30. Name and address of pelson who LARRY WATERBU	completed cause of	¥ath (Item 23a) IHBHC	(Type, Print) 4940	EAS	TERN.	AUE	E. BAA	LT. 40.	21	122.	4
	Sta		31. Date filed (Month, Day, Year)	100	ar's Signature	· Spa	M. a	-		1	, , , , ,			-
DI	Regist		APR 2	2 2005	Wester J.	· 1500					-			
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DHMH 17 Rev 1/2001

		1	_ State	tate of Maryland / Depa	artment of Health and M rtificate of Death		ne No.2005	13720
			Registrar  1. Decedent's Name (First, Middle, Last)			2. Date of Death		3. Time of Death
	Physicia			md+ Cm		April 19	Day Yeer 2005	1:30 p <sup>M</sup>
	/Medic		Joseph Henry Reinha  la. Fecility Name (If not institution, give stre	et and number)	4b. City, Town, or Location of Death		4c. County of Death	
	Examin	er '	654 St. Mary's Road		Pylesville		Harford	
			5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year   If Under 24 Hrs.	8. Date of Birth (Month, Day, Y	9. Birth	nplece (State or Foreign untry)
	Funeral	1	220-03-3669	2□ F 84 Yrs.	Months Days Hours Min.	May 21,	1920 Ma	ryland
	Director	-	Usuet Residence of Decedent					10d. Inside City Limits
	land		10a. State 10b. County	10c. City, Town or Le	ocation			1 ☐ Yes 2 ☐ No
	Mary Feb	ō	Md. Harford		Pylesville			X
	the 28s	rec	10e. Street and Number		10f. Zip Code		. Citizen of What Co	untry?
	3a of	Funeral Director	654 St. Mary's Road		21132		J.S.A.	
	ne 2	era		Was Decedent Ever in U.S. 13. Armed Forces?	Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White	
٥	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  Important: If item 27 is marked other than "natural", or iteme 23a or 28a-f ehow important: If item 27 is marked other than "natural", or item 23a or 28a-f ehow any fujury or other traumatic event, it a Medical Evan for mint be notified at once.		1 Never Married 2 Married	1 ☑ Yes 2 ☐ No If Yes, Give	1 ☐ Yes 2 ☑ No Specify:		Specify: W	hite
21215-0036	ours iral',	d by	3 ₩ Widowed 4 Divorced	Year or Dates:	edent's Usual Occupation	16	bb. Kind of Business/	Industry
'n	72 h	ete	15. Decedent's Educa (Specify only highest grade of	completed) (Giv.	e kind of work done during most of work  DO NOT use retired)	ing		
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2	Hygie Hygie Ther t	ပိ	12 years  17. Father's Name (First, Middle, Last)	macri		e (First, Middle, Ma	aiden Sumame)	
anc	d of other	Be	George Reinhardt		Mary Die	glman		
2	d Mer d Mer nark natic	ဥ	19a. Informant's Name/Relationship (Type	p. Print) 19b. Mai	ling Address (Street and Number or Rur	al Route Number,	City or Town, State, 2	Zip Code)
Maryland	d2 st th and 7 is r traur		Joseph H. Reinhardt		St. Mary's Road, P	ylesvill	e, Md. 211	.32
e,	1 and Heali em 2		20a. Method of Disposition	20b. Place of Disp	position (Name of ematory or other place)	Date 2	Oc. Location - City or	Town, State
Baltimore,	nt of nt of t: If it		1 Burial 2 ☐ Cremation 3 ☐ Re 1 Donation 5 ☐ Other (Specify)	noval from State	-	/2005 G	len Burnie	, Md.
뜶	artme ortani injury		21. Signature of Funeral Service Licensee		22. Name and Address of Facility Schimunek Funeral		Pol Air	Tnc
Ba	Departiment Important Important Income.		Buin a wi	elen	610 W. MacPhail F	oad Rel	Air. Md.	21014
			23a. Part1. Enter the disease, or complic	ations that caused the death. Do not e	nter the mode of dying, such as cardiac	or respiratory arres	st,	Interval Between
	3		shock, or heart failure. List only one	CONFERENCE	HEART FAIL	UNE		Onset and Death
}	Physician /Medical		disease or condition resulting in death)	Due to (or as a consequence of):	HEART FAIL	40.74		
	Examiner			ISCHEMI	C HEART P	1381758	?	
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Undertrying Cause (Disease or injury	Due to (or as a consequence of):				
	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Examiner	that initiated events C.					
o,	an ar	EX	resulting in death) Last	Due to (or as a consequence of):				
68760,	ite be iysici	edical	d.					
89	tifica ng ph as th	Jed	IF FEMALE:				22d Date of de	linear
Вох	leath certifica attending ph d for use as the	N/UE	23b. Was decedent pregnant		3 Ectopic pregnancy		23d. Date of de Month	Day Year
	ie deat the att	Physiclan/M	in the past 12 months? 1 □ Yes 2 □ No	4☐Pregnant at time of death : 9☐Unknown	5 Other (specify)		10	
P.0	at the de by the	h	9 ☐ Unknown  Part II. Other significant conditions con	why time to death but not regulting in the	a underlying cause given in Part I.	23e. Did tob	acco use contribute t	to the cause of death?
	res tha	ρ	Part II. Other significant conditions con		g underlying outdoor great in a least	1 □ Ye	s 2 <b>⊠</b> Ño 3∐ P	Probably 4 Unknown
ord	w require been si should	ted	HOWICE SICI			04. 14h. a	24h Wore a	utopsy findings available
Records,	aw reas be	Completed				24a. Was a autops perform	y prior to	completion of cause of
æ	The hard	LO.				1 □ Yes 2		s 2 No
Vital	ian: rtifica	Be	25. Was case referred to medical examiner?		Lau	ath Check onl on		
f V	Physician: rthis certific ral director.	10	1 ☐ Yes 2 No	ospital: 1   Inpatient 2   ER/Outpa			once 6 Other (Sp.	ecify)
o t			27. Manner of Death 1 €Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year) 28b. Time Injury	ry Work?	200. Describe no	, will all y occurred	
iois	Attending r death.	atle	2 Accident investigation			28f Location (SI	reet and Number or F	Rural Route Number,
Division	or Attender de Directe in by t	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, building, etc. (Specify)	, street, factory, office	City or Town	n, State)	
Ω	To the Hospitel or Attendii within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Ce	29a. Certifier 12 Certifying Physics	ician: To the best of my knowledge, d	eath occurred at the time, date and place	a, and due to the c	ause(s) and manner a	as stated.
	n 24 ho n 24 ho ne Fun bietely	Medical	(Check only 2 Medical Exami	ner: On the basis of examination and/o and manner stated.	or investigation, in my opinion, death occ	urred at the time, o	9d. Date signed (Mor	
	To the To the Comp	Σ	29b. Signature and title of certifier	valenskr us	DOSO 96			
	0	The state of the s	102-22					
Ī	116		30. Name and address of person who co	ompleted cause of death (Item 23a) (Ty	pe. Print) 125 N. M.	AIN ST.	BELAI	R, MD 21014
		tate	31. Date filed (Month PR 92) 2	005 32. in gistrar's Signature	Books			
	Regis	strar		1400000				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month Year **Physician** oulear 200 /Medical 7. Age (In yrs. last birthday)

Yrs.

The state of the st 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner etirement BAL TIMORE 6. Sex 1 M 2 □ F 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Min 393-14-969 Director Wisconsin Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland nent of Heatth and Mental Hygiene. ant of Heatth and Mental Hygiene. ant: If Item 27 is marked other than \*natural\*, or Items 23e or 28e-f show 10b County 10a State 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other than "natural", or Items 23a or 28a-f shov other traumatic event, If a Madical Extending 1 mart be notified at 1 Yes 2 No BALTIMORE Completed by Funeral Director Glen 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11630 2105 m 12. Was Decedent Ever in U.S. Armed Forces? 1 If Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 1 No Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) DIGNAL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) To Be Edward Kadiker-Oulean 19a. Informant's Name/Belationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If Item 27 is any Injury or other training. 20b. Place of Disposition (Name of cametery, crematory or city place) Glen Hem 20a. Method of Disposition

1 X Burial 2 Cremation 3 Removal from State 20c. Location - City or Town, State ` 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee uttothe EXCEPUL ALTERNATIVES FUNCEALGEREMATION SRVCS Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each ina Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospitel or Attending Physician: The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month 4☐Pregnant at time of death 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by ate has been signe page 2 should be A PORTENSON 2 No 3 Probably 4 Unknown 1 Tyes 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 1 Yes 2 25. Was case referred to medical 26. Place of Death (Check only one examiner? 2 KNO Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Tyes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred bath Certification: Injury 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 ☐ Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifie Roman A hoparanimo Name and address of person who completed cause of death (Item 23a) (Type, Print) RAMAN A (ROST ROBE) ING

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year)

egistrar's Signature

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April 20 Day **Physician** Inez O. Resh 6:00 a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3336 Lineboro Rd. Manchester Carroll | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | OCT | 49 | 906 7. Age (In yrs. last birthday)
98 Yrs. 9. Birthplace (State or Foreign Country) Mary Land 5. Social Security Number **Funeral** 214-26-3918 1□M 2\ F Director Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No **Funeral Director** Maryland Carroll Manchester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3336 Lineboro Rd. 21102 23a U.S.A. Pages 1 and 2 should be filed within 72 hours after death a nent of Health and Mental Hygiene. Int: If Item 27 Is marked other than "natural", or Items 23. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Be Completed by Specify: White 3 ☑Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Housewife Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Umberto Bavotta Chiarina 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles K. Resh Jr. - son 3336 Lineboro Rd. Manchester, Md. 21102 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a Method of Disposition 20c. Location - City or Town, State 5 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Important: If any injury or once. Baltimore National Cem. April 25,2005 Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Eckhardt Funeral 3296 Charmil Dr. 21. Signature of Funeral Service Licensee Chapel P.A. . Hat Eller Manchester, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) A-SCI /Medical Due to (or as a consequence of): Examiner amedranito Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760. Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) ed by the a 1 ☐ Yes 2 ☑ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, been signe should be d 3 Probably 4 Unknown 1 ☐ Yes 2 No 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? page 2 s 1 Yes 2 Z No 1 Yas or Attending Physician: director Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After thi funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death Natural 28d. Describe how injury occurred 5 Pending death. 1 ☐ Yes 2 ☐ No investigation ☐ Accident hours after deat 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) ģ 4 - Homicide within 24 hours a To the Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mariner stated. 29a. Certifier (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Alexander Box 31. Date filed (Month, Day, Year) APR 2 2 gistrar's Signature State 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item#19a-b, perFH, G842, 4/22/05 TI
State of Maryland / Department of Health and Mental Hygiene

Continue of Dooth 1 - For State Registrar Certificate of Death Req. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day APRIL 19 2005 Year **Physician** HILDA REISIG 2:50 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 6350 RED CEDAR PLACE UNIT #413 BALTIMORE N/A If Under 24 Hrs. 8. Date of Birth 0 7/03/1908 Birthplace (State or Foreign Country)
 MD 7. Age (In yrs. last birthday) If Under 1 Year Months Days 5. Social Security Number **Funeral** Hours 1□M 2₩F MD 96 Yrs 215-10-7151 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f show Items 23e or 28e-f showing must be notified at 1 X Yes 2 No BALTIMORE Funeral Director MD N/A 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 6350 RED CEDAR PLACE UNIT #413 21209 Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? the Medical Examiner 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married WHITE 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 5 Specify: Specify: Completed by 3 Widowed 4 Divorced neturel 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry then Elementary/Secondary (0-12) College (1-4or 5+) RETAIL BUYER 10 permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Importent: if item 27 Is marked othe any injury or other treumetic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) KAT7 REISIG PAULINE **MEYER** 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) SANORY COURT BALTIMORE, MD 21208 PAULA BERGER / NEICE NIECE 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State BALTIMORE HÉBREW CONG. 04/21/2005 BALTIMORE, MD of neral rvice Linse 4 Donavion 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signate 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) General debility ¿ ulcerations/decibito Pnysician 6 must /Medical Due to (or as a consequence of): **Examiner** ASUUD Years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed and Due to (or as a consequence of) attending physician a for use as the burial-Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No the a Division of Vital Records, P.O. 9□ Unknown 9 I Inknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 | Yes 2 | No 3 | Probably 4 | Unknown thromhophilia Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 Yes 2 400 To the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? completely filled in by the funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Cer iffication: within 24 hours after death. To the Funerel Director: After Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide Medical t Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 00004701 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SIH IMACINEN 31. Date filed (Month, Day, Year) 32. Raistrar's Signature Registra APR 2 2 2005

		_	1 - State Amend Items 23	State of Maryl	25 per 1	irment of F RECEASE of	leath and Death Death	Mental Hyg <b>hb</b>	gienė () () Reg. No.	5 13724
	Physicia /Medic		1. Decedent's Name (First, Middle, Last	•				2. Date of Dea Month	Day	3. Time of Death Year 2005 1:50 P M
	Examin	er		agriew med	il Onth	Bultim	r Location of Deat		4c. County of	mD
	Funeral Director		5. Social Security Number 6. Se 217-54-2930  Usual Residence of Decedent	744 007	yrs. last birthday) 82 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		y, Year)	Birthplace (State or Foreign Country)     Turkey
	f show	or	10a. State 10b. County  Maryland N/A	100	City, Town or Lo					10d. Inside City Limits  Y☐ Yes 2☐ No
	or 28e-	Director	10e. Street and Number	<u> </u>	Dartimo	10f. Zip Code			10g. Citizen of W	
)36	Jamin 72 nous and used with the maryand jiene. Trien medical Examiner must be notified at	by Funerai	2108 St. Paul  11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 Yes X No	ecedent of Hispanic Origin? (Specify Yes or No- specify Cuban, Mexican, Puerto Rican, etc.)			d States - American Indian, k, White, etc. White
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yland	should be lifed ind Mental Hygis marked other umatic event, II	To Be C	17. Father's Name (First, Middle, Last) Xoypmoyzis	Ranou			Alkate		Siro	glu
	ulth ar 127 ls r treu		Mr. Emilios Gaita	nidis/Nephew		ng Address (Street  O Fredric		Reading	, PA 19	9605
	rage nent o ant: tf ury or		20a. Method of Disposition  1 Deurial 2 Cremation 3 1  4 Donation 5 Other (Specify,	Removal from State	reek Ort	hodox Cei	m. 4/2	5/2005	Woodlaw	city or Town, State
Ba	permit. Pra Departmer Importent eny injury		21. Signature of Funeral Service Licens	Provider E.	carrapp	Leonard	J. Ruck,	Inc. B	305 Harf altimore	
	Medical Examiner	Examiner	23a. Part1. Enter the disease, or comp shock, or heart failure. List only commediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	a. Due to (or as a cor	nsequence of):	Hospit Bowel	A AC	CHVI. C	1951,	Approximate Interval Between Onset and Death Death
8760,	cate be executed physician and the burial-transit	dical	resulting in death) Last	Due to (or as a cord.	nsequence of):			Mm	DICAL EXAMINER	0
.O. Box 6	I ne law requires that the death certifics tte has been signed by the attending pt bage 2 should be detached for use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9  Unknown	23c. If yes, outcome of pr 1 Live birth 2 L 4 Pregnant at time 9 Unknown	Fetal death 3	□Ectopic pregnanc □ Other (specify) _		APPROVED BY MED	23d. Date Mon	e of delivery hth Day Year
Records, P	w requires that been signed t should be det	by	Part II. Other significant conditions of	entributing to death but no	t resulting in the u	Inderlying cause giv	ven in Part I.	23e. Did to		ibute to the cause of death?  3 Probably 4 Unknown
		Completed	Ischemic bowel					24a. Was autop perfo 1  Yes	osy p rmad2 d	Vere autopsy findings available rior to completion of cause of eath?
	Atending Physicien: In r death. ector: After this certificate by the funeral director, pag	ation: To Be	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	Hospital: 1 Inpatient 28a. Date of Injury (Month, Day Yea	2 ER/Outpatier 28b. Time of Injury	of 28c. Injur	ner: 4 Nursing I	eath (Check only on the state of the state o		
É	i gite	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - building, etc. (S)	pecify)			City or Tox	vn, State)	er or Rural Route Number,
	To the Hospitel within 24 hours a To the Funerel I completely filled	ledicai	(Check only 2 Medical Exemone)	rsicien: To the best of my iner: On the basis of exa and manner stated.	knowledge, deat mination and/or in	vestigation, in my o	opinion, death occ	urred at the time,	date and place, a	and due to the cause(s)
)	vitt To COL	N	29b. Signature and title of certifier	2 mp		12E	5-000	)	April (	(Month, Day, Year)
	G Sta	ate	30. Name and address of person who of Many Robert MD 31. Date filed (Month, Day, Year)	completed cause of death  50/04 1704  32. Registrar's 5	(Item 23a) (Type, BW Signature	Print) 4VIW 4	140 East U	n Ave	Baltin	wre MDZIZZ

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.-2. Date of Death 1. Decedent's Name (First, Middle, Last) April 18, 2005 11:50 P M Reiss Marie 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Lorien Nursing & Rehabilitation Center Baltimore If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) February 11, 1935 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex Days Hours 1 ☐ M 2 💢 F Maryland 70 Yrs. 213-32-2308 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1X Yes 2 No Baltimore Marvland N/A 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21206 4503 Woodlea Avenue 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No If Yes, Give X Year or Dates: Specify White 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Food Fair Secretary 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Lillian Stetter John W. Reiss 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5209 Barbara Avenue Baltimore Maryland 21206 Gerard Reiss/Brother 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Most Holy Redeemer 1 XBurial 2 Cremation 3 Removal from State 4/22/05 Baltimore Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Leonard J. Ruck, Inc 5305 Harford Road Baltimore Maryland 21. Signature of Funeral Service Licensee Christina L. Hilton 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Algheiner's Type Dementin Due to (or as a consequence of):

Physician /Medical Examiner

Department of Important: If any injury or once.

Physician

/Medical

Examiner

10a State

**Funeral** 

Director

or Itams 23a or 28e-f show

Director

Completed by Funeral

Be

other treumatic event, the Medical Examiner must be notified at

Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene.
ant: If itam 27 Is marked othar than "natural", or Itams 23 ury or othar treumatic event, the Modical Extending that the

Baltimore, Maryland 21215-0036

Box 68760,

Division of Vital Records, P.O.

Hospital or Attending Physician:

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requires that the death certificate be executed

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attending physician and for use as the burial-transit Physician/Medical þ Completed ပ

Examine

IF FEMALE:

Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 9 🗌 Unknown

3 Suicide

29b. Signate

1 ☐ Yes 2 No 27. Manner of Death 1 Natural 2 Accident 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

23b. Was decedent pregnant in the past 12 months? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner?

5 Pendina investigation 6 Could not be determined

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of

Due to (or as a consequence of):

Due to (or as a consequence of):

23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death

9 Unknown

4 ☐ Pregnant at time of death

Injury

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

3 Ectopic pregnancy

5 ☐ Other (specify)

Other: 4 ursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

26. Place of Death Check onl one

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Baltimore

24a. Was an autopsy performed

2 U No

29c. License number 7 43386 29d. Date signed (Month, Day, Year) 4.20.05

mo

23d. Date of delivery

Day

24b. Were autopsy findings available prior to completion of cause of death?

21217

1 ☐ Yes 2 ☐ No

Month

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1714 R. llowand

31. Date filed (Month, Day, Year)
APR 2 2 2005

32. Agistrar's Signature

Place

State

Registrar

State of Maryland / Department of Health and Mental Hygiene [15] 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Clarance Reichenbach, Sr. Herbert 11:45 A<sup>M</sup> April 4. 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Co. Towson Gilchrist Center 8. Date of Birth (Month, Day, Year) April 14,1928 If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 X M 2 □ F Director Pennsylvania 76 210-12-8139 Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be nutified at Director Dundalk 1 ☐ Yes 2 ☐ No Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21222 United States 827 Jaydee Avenue Items 23a Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14 Race - American Indian. 11. Marital Status Black, White, etc. XYes 2 fYes, Give 1 Never Married 2 Married 2 No ō 1 ☐ Yes 2 No Specify: 3 X Widowed 4 □ Divorced Year or Dates: White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Eiementary/Secondary (0-12) College (1-4or 5+) Laborer Rail Road 7 Years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) es 1 and 2 should be fill of Health and Mental H fitem 27 Is marked oth Be Schuck Maurice F. Reichenbach Ella 19a. Informant's Name/Relationship (Type, Print) Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2826 South Brook Road Dundalk, Maryland Mrs. Karen Cosentino-Ambrosino 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages nent of Fant: If ite 1X Burial 2 ☐ Cremation 3 ☐ Removal from State ö permit. Page Department of Important: If any injury or once. Sacred Ht. of Jesus Cem. 4/16/2005 Dundalk, Maryland \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign was of Funeral Service Licenses 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Line only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician onto cellular carcinoma months disease or condition resulting in death) /Medical Due to (or as consequence of) Examiner 5 cuantially list and fluns if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the burial-transli Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown ģ signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. Be Completed by disense 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 2 No Vital 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ £P/Outpatient 3 ☐ DOA 2 1 Tes 2 No of this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: After Division Hospital or Attending 1 Natural 5 Pending death. 1 Yes 2 No 2 Accident investigation after death 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide A 24 hours the Funeral Dire 29a. Certifier 1 Decrtifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0 11 4,2005 1)25205 511 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701 N. Chales St. Balto Mr 2120x 6-BMC 31. Date filed (Month, Day, Year) 32. Registrar's Signature APR 2 2 2005 Bloom & Sports Registrar

Herbert Reichen back

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] 5 1- State Registreramend item #3 PER FH C842 4/27/05/cate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year Kendall 6:00PM 17 2005 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Yown, or Location of Death Examiner Be Hoopital Baltimore (
If Under 1 Year | If Under 24 Hrs. C:+y Hopkins Johns 8. Date of Birth (Month, Day, Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Gountry) **Funeral** 215-23-571 Days 1 M 2□F Months Hours Min. Yrs. Director Usual Residence of Deceden death with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show ust be notified at 1 Yes 2 No **Funeral Director** more Vlaryland 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ō 21 or Items 23a on 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 XNo
If Yes, Give Pages 1 and 2 should be filed within 72 hours after des ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items uny or other traumatic event. If a Modiful Exe. it en. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status American Indian Black, White, etc. 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Be Completed by 3 ☐ Widowed 4 ☐ Divorced lf Yes, Give 1 Year or Dates: 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or, 5+) Disabled Disablea Disabled 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) savage 19a. Informant's Name/ | lationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 all 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 4/27 \$2005 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Department o Important: If any injury or once. Memorial Park \* 4 ☐ Donation 5 ☐ Other (Specify) Ting 21. Sign ture of Funeral Service Licenses 22. Name and Address of Facility Funeral Home Joseph L. Russ Fur 2222 W. North Ave. 23a, arti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Sepsis

Due to (or as a consequence of): day /Medical **Examiner** Sequentially list conditions, any learning to a large cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to for as a consaduence of or Attending Physician: The law requires that the death certificate be executed as the burial-transit Due to (or as a consequence of): Box 68760 IF FEMALE: for use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day 4 Pregnant at time of death 5 Other (specify) P.0. ed by the a page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ of Vital Records, henortage 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed dis orde 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 25. Was case referred to medical examiner? 1X Yes 2 No director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification; To 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 2 Accident Injury 5 Pending after death. investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide 24 hours a 29a. Certifier 🗠 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) within 2 To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier RES-000 April 18, 2005 who completed cause of death (Item 23a) (Type, Print) WOLFE 600 NORTH 31. Date filed (Month, Day, Year) State

Registrar

			1 - For State Registrar	State of Maryland /			lealth and		_	13728
)	Physici /Medio Examir	al	Decedent's Name (First, Middle, Last)     Guy Edward      Facility Name (If not institution, give street     National Lutheran			4b. City, Town, o			Day Year 2005  4c. County of Death	3. Time of Death 9:05 PMM
	Funeral Director		5. Social Security Number 6. Sex	7. Age (In yrs. last b	oirthday) Yrs.	Rockvi  If Under 1 Year  Months Days	ITE If Under 24 Hi Hours Mi		Montgomer Year) 9. Birthr Cour 1923 West	place (State or Foreign
<b>.</b>	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatilt and Mental Hygiene. Department of Heatilt and Mental Hygiene. Inportent: If item 27 is marked other than "neturel", or items 23a or 28e-f show any injury or other treumatic event. The Medical Evans are must be notified at once.	by Funeral Director	VA Shenandoa  10e. Street and Number  102 Royal Avenue	. Was Decedent Ever in U.S. Armed Forces?	sbur	g 10f. Zip Code 2265	lispanic Origin?	Specify Yes or No-		10d. Inside City Limits 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
ınd 21215-0036	be filed within 72 hours at tal Hygiene. d other than "neturel", or event, the Medical Evan	To Be Completed by	3 Widowed 4 Divorced  15. Decedent's Educa (Specify only highest grade of the control of the con	If Yes, Give Year or Dates: WWII tion tion completed) College (1-4or 5+) 4	a. Deced (Give life. L	l Yes 2 No  dent's Usual Occup kind of work done DO NOT use retired ence Tead	during most of with the cher  18. Mother's No.	orking ame (First, Middle, M	6b. Kind of Business/In  Education  aiden Sumame)	ite
e, Maryland	1 and 2 should lealth and Men am 27 Is marke ther treumatic	10	Guy Noris Shafferm  19a. Informant's Name/Relationship (Type Betty Lou Shafferm  30a. Method of Disposition	an - Wife	970		and Number or I	ville, MD	City or Town, State, Zip 20850	
Baltimore,	permit. Pages 1 Department of H Importent: If ite any injury or ot once.		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ Rer  '4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service icensee	noval from State cemet	rama 22 S	Mem. Gdr Name and Addre Lover Fur	ns. 4- ss of Facility neral Ho	21-05 V	oc. Location - City or To Varren Co., Casburg, VA	
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P.O. Box 68	Attending Physicien: The law requires that the death certificate be executed refault.  refault.  stor: After this certificate has been signed by the attending physician and stor: After this certificate has been signed by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	. If yes, outcome of pregnancy 1 Live birth 2 Fetal deat 4 Pregnant at time of death 9 Unknown		Ectopic pregnancy Other (specify)	,		23d. Date of delive Month	ory Day Year
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Division of Vital	tending Physici eath. tor: After this cer the funeral direc	Certification: To B	27. Manner of Death  1 Patural 5 Pending 2 Accident investigation	(Month, Day Year)	. Time of Injury	28c. Injur Worl M 1 []	er: 41 Nursing	Home 5 Residen 28d. Describe how	ce 6 ⊡Other (Specify rinjury occurred	
É	i Zife		4 Homicide determined  29a. Certifier 1 Certifying Physic	28e. Place of Injury - At home, building, etc. (Specify) ian: To the best of my knowled	ge, death	occurred at the tin	ne, date and place	City or Town,	ise(s) and manner as st	ated.
	To the Hospitel within 24 hours a To the Funerel I completely filled	Medical	29b. Signature and title of certifier	r: On the basis of examination a and manner stated.		29c. Licensi			e and place, and due to	
	Sta Registr		30. Name and address of person who com Charles W. Ka:  31. Date filed (Month, Day, Year)	resh, MD 26033			Damasc	us, MD 208	72	

		For	State of Marylan				-	•	
	1	For State Registrar		•	tificate of D			eg. No.	0 13/29
Physicia		Decedent's Name (First, Middle, Last	")				2. Date of Deat	th Day	3. Time of Death
/Medic	al -	Alice Joan Scrugg.  4a. Facility Name (If not institution, give			4b. City, Town, or	Location of Death	HOU	4c. County of	Death O SUFFI
Examin	er	Doctors Community			Lanham	LOCATION OF DOUGH	·	1	George's
Funeral		5. Social Security Number 6. Se	x 7. Age (In yrs.		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day)	Year)	9. Birthplace (State or Foreign
Director	}	585-07-4096 10 Usual Residence of Decedent	JW ZLA	62 Yrs.			Aug. 2	1942	New Mexico
yłand how		10a. State 10b. County		y, Town or Lo	cation				10d. Inside City Limits
e Ma	ctor	MD Prince G	eorge's Mi	tchell					1 ☐ Yes 2 ☐ No
with the	Funeral Director	10e. Street and Number 4008 Romsey Drive			10f. Zip Code 20721		1	0g. Citizen of Wh	at Country?
death	eral	11. Marital Status	12. Was Decedent Ever in U.	.S. 13. V	Was Decedent of His f Yes, specify Cubar	spanic Origin? (Spe	ecify Yes or No-		- American Indian,
after or Ita	Fur	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give		t Yes, specity Cubar 1 ☐ Yes 2 🎇 No	Specify:	Hican, etc.)	Specify:	White, etc.
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at yielitid ZIZI3-0030 should be filed within 72 hours after death with the Maryland and Martle Hygiene. In arked other than "nature!", or items 23a or 28a-f show unatic event, I're Madical Examiliant and the matified a	To Be	17. Father's Name (First, Middle, Last) John A. Scruggs				18. Mother's Name			1
should and Mer marke matic	2	19a. Informant's Name/Relationship (7	vpe. Print)	19b. Mailin	ng Address (Street a		Cliffor		tate. Zip Code)
INICA nd 2 saith ar 27 is ir treu		John Scruggs, Jr.			516 23rd 1			-	
patitificities in Marylatin Z.I.Z.1.3-00.30 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mentall Hygiene. Department of Health and Mentall Hygiene. Department of Health and Mentall Hygiene. San injury or other treumatic event, the Madical Extraclinative as the notified at page.		20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐	20b. F		sition (Name of matory or other place				Sity or Town, State
Dallinor Demit. Pages Department of mportent: If it any injury or o		*4 □ Donation 5 □ Other (Specify	La	urel H	ill Cemet	ery Apr 1	8, 2005	Thomasv	ille, GA
Dermit Depart Mpor		21. Signature of Funeral Service Licen	BOALD #CCO:	-	Name and Address				
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/Medical		resulting in death)	a. Due to (or as a conseq	uence of):	Em.				
Examiner	_	Sequentially list conditions,	b. LUNG	uence of):	ANC	在几			_
nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	AOR 7	derica ory:	S :	TENC	25,	2	
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the d	Physi	1 □ Yes 2 ZNo 9 □ Unknown	9□ Unknown						
ords, r.C. requires that the een signed by th hould be detache	by P	Part II. Other significant conditions of	ontributing to death but not res	ulting in the u	nderlying cause give	en in Part I.		_	oute to the cause of death?
requ been hout	eted						-		B ☐ Probably 4 ☐ Unknown
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	e Co	25. Was case referred to medical				26. Place of Death			Yes 2 No
	To B	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatient 2	ER/Outpatien	nt 3 DOA Othe	er: 4 Nursing Ho			(Specify)
		27. Manner of Death  1 ■ Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	f 28c. Injury Work	at ?		ow injury occurred	
tor the	ertification:	2 Accident investigation 3 Suicide 6 Could not be		ome farm str		Yes 2□No	28f Location (S	treet and Number	r or Rural Route Number,
UNISION ARTENIA I DI PERCENTIA	ertil	4 Homicide determined	building, etc. (Special		oot, tadiory, office		City or Tow		
To the Hospitel or Al within 24 hours after of To the Funeral Direc completely filled in by	calC	29a. Certifier 1 Certifying Ph	ysician: To the best of my kno niner: On the basis of examina	wledge, death	h occurred at the tim	e, date and place,	and due to the c	ause(s) and manr	ner as stated.
To the H within 24 To the F complete	Medical	one)	and manner stated.	THO TENDO IN	29c. License				
To To	-	29b. Signature and title of certifier		M	D 1 5		_ 1	-	(Month, Day, Year)
1		30. Name an address of person who	completed cause of death (Iter	n 23a) (Type.	Print)	0 ( 1		4-1	20770
		Cecil D. Georg	e MD. 7305	A. Ha	anover PK	wy G	reenbel	+, mD	20770
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DHMH 17 Rev 1/2001

		1	For State Registrar		State of M	laryland		tment of				giene)	05	137	30
			Decedent's Name (Fit	rst, Middle, Last	')						. Date of Dea	ith		3. Time of	Death
	Physicia		EFFIA	Ren	MOTON	50	CHEN	SK			Month	19 7	Yeer	850	MA
	/Medic Examin	_	4a. Facility Name (If not	institution, give	street and number			b. City, Town,	or Location	of Death		4c. County	of Death		
			UPPER CH	ESAPE.	AKE HE	WITH C		ISEL.	AIR			HA	ZFO(	20	
	Funeral		5. Social Security Numb	6. Se	x 7. A	lge (In yrs. la	A A	If Under 1 Yea Months Day:		Min.	. Date of Birtl (Month, Day	, Yeer)	9. Birthp Coun	lace (State of	r Foreign
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	wc #C			b. County		10c. City,	Town or Loca	tion					11	0d. Inside Cit	ty Limits
	Mary -1 sh	to	WD F	HARFOR	20	RE	IL A	NR						1 🗌 Yes	2 No
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	ems er.	ner	11. Marital Status		12. Was Deceder Armed Forces	s?/	i. 13. Wa	as Decedent of es, specify Cu	Hispanic C ban, Mexica	rigin? (Speci an, Puerto Ri	ty Yes or No- can, etc.)		ce - Americ ck, White, (		
36	hours after tural, or ite at Expression	by Fu	1 ☐ Never Married 3 ☐ Widowed 4 ☐		1 Tes 2 If Yes, Give Year or Dates		10	Yes 2 N	o Specify	y:		Specif	y: W	HITE	-
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Maryland	should be and Mental marked of	2	1 Hom AS	TREDE	RICK	DKI	UNTO			ARY			F10	HAU	
lar	2 m m		19a. Informant's Name				212	1		-00	1	r, City or Town	, State, Zip	Code) 48	, <del>0-18</del>
_	1 and Health tem 27		20a. Method of Disposit		1 200		ace of Disposit		AT HI	ER JOK	· Contraction	20c. Location	- City or To	wn. State	
Ö			1 □ Burial 2 ☑C	remation 3 🗆		Ce Ce	metery, crema	tory or other p		11 1-	6	-0		الك ا	MN
altimore			4 □Donation 5 □ 21. Signature of Funera					Vame and Add		4-20		neral			1 140
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	/Medical		disease or condition resulting in death)		a. Due to (or	as a consequ	ence of):	m	· · ·	fred a	m	) 20-			
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60,	be executed sicien and burial-transit	E	, southing in south, south		Due to (or -	as a consequ	erice or).								
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9 X	eath certific attending p	/Me	IF FEMALE: 23b. Was decedent pre	ognost.	23c. If yes, outcor	ne of pregnar	ncy					23d. Da	ate of delive	ery	
Вох	eath atter	ciar	in the past 12 mg	Inths?	4 Pregnant	2 □Fetal at time of de		ctopic pregnar Other (s <i>pecify)</i>				М	onth	Day 1	Year
0	that the de led by the a detached	Physician/Me	9 Unknown		9□ Unknowr	1					T				
٦,	The law requires that the death certificate be executed at the las been signed by the attending physicien and rage 2 should be detached for use as the burial-transit	by P	Part II. Other significat	nt conditions of	ontributing to deat	h but not resu	Iting in the und	lerlying cause	given in Par	t I.	_	obacco use con			
of Vital Records,	w require been sig should b	ed									1 1	kes 2□No	3 Prob	ably 4 🔲	Jnknown
900	e law re has be je 2 sho	Completed									24a. Was autop	SV	prior to con	psy findings and pletion of ca	available ause of
H	The late he	mo:									perfq 1 ☐ Yes	rmed? 25 No	death? 1 ☐ Yes	20 No	
/ita	ysicien: Th iis certificate director, pag	Be (	25. Was case referred examiner?		113-1-5					ice of Death	Check only c	ne)			
£	hysio this c	L <sub>O</sub>	1 ☐ Yes 2 ☐ No		Hospital: Unp		ER/Outpatient 28b. Time of	3L DOA				dence 6 Ot		y)	,
n c	ding Phy h. After thi funeral	lon:		5 Pending	28a. Date of I (Month,	Day Year)	Injury	28c. In	vork? □Yes 21	,	u. Describe i	TOW INJURY COOL	1100		
Division	death ctor; the	licat	2 Accident 3 Suicide	investigation	28e, Place of	Injury - At ho	me, farm, stree					Street and Num	ber or Rura	l Route Num	nber,
Ď	after Dire	Certification:	4 Homicide	determined	building,	etc. (Specify	")				City or Tov	vn, State)			
	spita nours inerel y filled		29a. Certifier	Certifying Ph	ysicien: To the be	st of my know	wledge, death	occurred at the	time, date	and place, ar	d due to the	cause(s) and m	anner as s	tated.	-)
	To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director, After this certifica completely filled in by the funeral director, i	Medicai	one)		niner: On the basi and manner		JOH ANG/OF INVE								7
	To t To t	Σ	29b. Signature and title	e of certifier					ense numbe			29d. Date sign			-
			) V>0	ival	277				3553	<i>i</i> )		April		5062	
ì	2		30. Name and address		'				. 0	h 4 ]	Ω	10.0	ma		
	C	ate	31. Date filod (Month,	Day, Year)	1) 5 X	istrar's Signal	ture L	<u> , , , , , , , , , , , , , , , , ,</u>	~ 81	).q. (	176	19. /	(1)		
	Regist		APF	2 2 2 201	05 Blee	צל עם	ture spea								

Schenk, Freda

Jenise Smith 05-02741 RJ

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

4b. City, Town, or Location of Death

April 19

Baltimore, Md

29d. Date signed (Month, Day, Year)

Baltimore, Maryland 21201

April 19, 2005

2005

4c. County of Death

1- State Unpend Ityem State of Mar 25a pf, pt.	rland/Department of Health and N Certificate of Death	Agntal Hygiene 0 5	1373
Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Deat
Jenis	se Smith	Month Day Year	02 /7

**Physician** /Medical Examiner

4a. Facility Name (If not institution, give street and number)

**Funeral** Director

Baltimore, Maryland 21215-0036

**Physician** /Medical **Examiner** 

within 24 hours after death. To the Funeral Director: After

To the Hospitei or Attending Physicien: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

	Union Mem	orial	Hospi	tal			Bal	timo	re					
	5. Social Security N	lumber	6. Sex		ge (In yrs. I	ast birthday)	If Unde Months	r 1 Year Days	If Under	24 Hrs. Min.	8. Date of Bi	rth	9. B	irthplace (State or Foreign
	213-79-4	4333	1 M	<b>2</b> €	45	Yrs.	MOTITIES	Days	Hours	With 1.	Jan 10	), 1960	,	Md.
	Usual Residence of	Decedent												
	10a. State	10b. Count	ty		10c. City	, Town or Lo	cation							10d. Inside City Limits
ctor	Md.		N/A					Ba	ltimore	:				1 Yes 2 No
i-e	10e. Street and Nui	mber					10f. Zip	Code				10g. Citize	n of What (	Country?
aiD	2533 Board	man Ave	nue						212	15			U.S	S.A.
nue	11. Marital Status			Was Deceder Armed Forces		S. 13. V	Vas Dece f Yes, spe	dent of H	ispanic Oi n, Mexica	rigin? (Spi n, Puerto	ecify Yes or No Rican, etc.)	D- 14	. Race - An Black, Wh	nerican Indian, nite, etc.
d by Fi	1 🕅 Never Marr 3 🗆 Widowed			l □Yes 2 <b>∑</b> If Yes, Give Year or Dates			□ Yes		Specify				pecify:	Black
etec	(Spec		ent's Education			16a. Deced	kind of wa	ork done d	turing mo:	st of work	ing	16b. Kind	of Busines	s/Industry
ompl	Elementary/Seco			College (1-4o	r 5+)	`life. L	DO NOT u		emake	r	ŭ		Own	Home
To Be Completed by Funeral Director	17. Father's Name		, Last) Iliam E. S	mith					18. Moth	er's Name	(First, Middle	, Maiden Su Ioria Sm		
ř	19a. Informant's Na	ame/Relation	nship (Type,	Print)							al Route Numb		own, State,	Zip Code)
	Sylvia Whit				1				Road		ore, Md. 2			
	20a. Method of Dis 1 X Burial 2 3 4 □ Donation	Cremation		oval from Stat		lace of Dispo- emetery, cren Mt.	sition (Nai natory or C Zion C	other plac			04/27/05	20c. Loca	100	or Town, State ore , Md.
	21. Signature of Fu	Ineral Service	e-Licensee	Esta	70	22	E	step B	s of Facil rothers	Funer	al Service	d 21217		
Г	23a. Part1. Enter to shock, or hea	he disease, o rt failure. Lis	or complications on second	ons that cause ause on each	ed he death	. Do not ente								Approximate Interval Between Onset and Death
	Immediate Cause disease or condition resulting in death)	(Final In	а. Р	neumon	ia									Oriset and Death
	resulting in deatin,			Due to (or a			<b>.</b> .							
_	Sequentially list co	nditions,	ь. А	cquire	d Lmm	une De:	ticie	ency	Synd	rome				
Ę	Sequentially list co if any, leading to in cause. Enter Under Cause (Disease or	riying . iniurv	< −	220 10 (0, 2	0 4 00/10040	01,00								
xan	that initiated events resulting in death)	5	c	Due to (or a	s a consequ	ience of):								
lical			d											
Mec	IF FEMALE:		020											
by Physician/Medical Examiner	23b. Was deceden in the past 12 1 Yes 2 [ 9 Unknown	months?	1	lf yes, outcom 1 □Live birth 4 □ Pregnant 9 □ Unknown	2 Fetal	death 3	Ectopic p					230	I. Date of de Month	elivery Day Year
/ Ph	Part II. Other signif	icant condit	tions contrib	uting to death	but not resu	ılting in the ur	nderlying o	cause give	en in Part	l.	23e. Did 1	obacco use	contribute	to the cause of death?
O	Methado	ne Int	oxicat	ion							10	Yes 2 V	o 3□F	Probably 4 Unknown
Complete											24a. Was auto perfo	psy	24b. Were a prior to death?	
a	25. Was case refer	red to medic	al					-	26. Place	e of Death	(Check only			
OB B	examiner?	No	Hosp	ital:	tient 2XX	ER/Outpatien	t 3 🗆 D0	Othe			me 5□Resi		Other (Sp.	ecify)
ation; T	27. Manner of Deat  1 Natural 2 Accident	5 Pend	ing F	8a. Date of In Outful -18-05	jury ay Year)	28b. Time of <b>Fourid</b> 6:00	-	28c. Injury Work	at ?		28d. Describe			unk
ertification;	3 Suicide 4 Homicide	6X Could deten	mined 2	8e. Place of I	njury - At ho etc. (Specify	me, farm, stre	-	y, office	Λ		28f. Location ( City or To		_	Bural Route Number, Boarman Ave.

DHMH 17 Rev 1/2001

State Registrar 29a. Certifier

29b. Signature and title of certif

Name and address of person who completed cause of deat

Registrar

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2X Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

OCME

111 Penn Street

			State Registrar	State of Maryland / Dep	partment of Health and Mertificate of Death	ental Hygie	ne	13732	
	Physici	an	Decedent's Name (First, Middle, Last)  ARTHUR  I	EE SMITH Jr		Date of Death     Month	Day Year	3. Time of Death 2:40 A M	
	/Medio		4a. Facility Name (If not institution, give str		4b. City, Town, or Location of Death	APRIL I	4c. County of Death	2:40 A W	
	Exami	lei	13501 Reid Circl		Fort Washingto	n	Prince	Georges	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthda		8. Date of Birth (Month, Day, Yo	9. Birthp	lace (State or Foreign	
	Director	ļ	135-34-5144	63 Yrs.		April13	,42 Virg	inia	
	yland now		10a. State 10b. County	10c. City, Town or	Location		1	0d. Inside City Limits	
	a-fet	ctor	Maryland Prince	Georges Fort	Washington			1 🙀 Yes 2 🗆 No	
	ith tha	Oire	10e. Street and Number		10f. Zip Code	10g.	. Citizen of What Coun	try?	
	s 23a	rai	13501 Reid Cir		20744		U.S.A.	T	
396	s 1 and 2 should be filad within 72 hours after deeth with tha Maryland I Health and Mental Hygene. I Health and Mental Hygene. Item 27 is marked other than "natural", or itams 23a or 28s-f ehow other traumatic event, the Wedest Examinational Demotified at	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	. Was Decedent Ever in U.S. Amed Forces?  1. A Yes 2 \( \) No If Yes, Give Year or Dates:	. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☐ No Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: Black		
200	72 ho	Completed	15. Decedent's Educa (Specify only highest grade of		edent's Usual Occupation re kind of work done during most of worki	161	b. Kind of Business/Ind		
21215-0036	within iene. than	mpte	Elementary/Secondary (0-12)	College (1-4or 5+)	DO NOT use retired)				
22	filad within Hygiene. other than *		1 2 17. Father's Name (First, Middle, Last)		Self- Employed	(First, Middle, Ma	laster Car	rpenter	
Maryland	ould be f Mental H wrked of	To Be	Arthur Lee Smit	h Cr	Emma		oberts		
ary.	2 should and Men is marke sumatic	F	19a. Informant's Name/Relationship (Type					Code)	
	1 and 2 Health a tem 27 is		Wife/Shirley W.H	ill Smith For	Ing Address (Street and Number or Rura Reid Circle Washington, Mar	yland 2	0744		
ore	0 0		20a. Method of Disposition 1 □8urial 2 □ Cremation 3 □ Rer	20b. Place of Dis			c. Location - City or To		
Baltimore,	parmit. Pages Department of I Important: If it any injury or o		* 4 ☐ Donation 5 ☐ Other (Specify)	Gracel	and Memorial 4/2	23/05 Ke	nilworth	N.J.	
Bai	parmit Depar Impor any in		21. Signature of Funeral Service Licensee		22. Name and Address of Facility				
			23a. Part1. Enter the disease, or complica		Adams Funeral Ho			MD 20608 Approximate	
b			shock, or fleart failure. List only one Immediate Cause (Final	cates on each line.	,			Interval Between Onset and Death	
	Pnysician /Medical		disease or condition resulting in death)	LIVER CANCER  Due to (or as a consequence of):					
5	Examiner	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence of):					
o,	ate be executed hysicien and the burial-transit	Examiner	cause. Enter Underlying Cause. Discuss or know that initiated events resulting in death) Last	Due to (or as a consequence of):					
8760,	ate be hysicie	ledicai	d			-			
O. Box 6	The law requires that the death certificate be executed that has bean signed by the attending physicien and bage? should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		□ Ectopic pregnancy □ Other (specify)		23d. Date of delive Month	ny Day Year	
<u>ה</u>	s that ned b	by Pr	Part II. Other significant conditions contr	buting to death but not resulting in the	underlying cause given in Part I.	23e. Did tobac	co use contribute to th	e cause of death?	
g	quires in sign					1 ☐ Yes	2□No 3□Prob	ably 4 Unknown	
Records,	aw requir as baan si 2 should	Completed				24a. Was an	24b. Were autor	psy findings available	
œ _	The lay ata has page 2	Com				autopsy performe 1 Yes 24	d? death? No 1 ☐ Yes	npletion of cause of 2X No	
Vital	ding Physicien: The h. After this certificata hi funeral director, page	Be (	25. Was case referred to medical examiner?		26. Place of Death	(Check only one)			
<del>6</del>	Physic this c	2	1 ☐ Yes 2 <b>X</b> No	spital: 1 Inpatient 2 ER/Outpat			e 6 Other (Specify	′)	
Division	Attending F r death. actor: After by the funer	Certification:	1 X Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year)  28b. Time Injury	Work? M 1 □ Yes 2 □ No	28d. Describe how		10	
Ö	Dir		4 Homicide determined	28e. Place of Injury - At home, farm, building, etc. (Specify)		City or Town, S	·		
	@ (V @ D)	Medicai	29a. Certifier 14 Certifying Physic (Check only one) 2 ☐ Medical Examine	<ul> <li>r: On the best of my knowledge, de</li> <li>r: On the basis of examination and/or and manner stated.</li> </ul>	ath occurred at the time, date and place, a investigation, in my opinion, death occurre	ed at the time, date	and place, and due to	the cause(s)	
	To the vithin To the comple	2	29b. Signature and title of certifier  Much Buc	Konerp	DC-MD33255		PRIL 18, 20		
1	51		30. Name and address of person who com KAREN AND BLACKSTON		e, Print) IRIVNG STREET NW, V	WASHINGTO	N,DC 20422	/688	
	St Regist	ate rar	31. Date filed (Month, Day, Year)	32. Registrar's Signature					
DH	MH 17 Rev 1/2	2001	ALA Z Z	2005 Beau Di	Spertie				
				ORIGIN	IAL				

20)		·	State of Maryland / Dep 1 - For State Unpend Item 23a&27 per me G842-4	artment of Health and N 	lental Hygie	Png 005 13733
			Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death
	Physici /Medio		Steven Charles Stack		APRIL	15, 2005 8:33a M
	Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
			303 SOUTH CAROLINA	STEVENSVILLE		QUEEN ANNES
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 200–03–2188 1 \text{ M 2 F } 84 Yrs.	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Y	7000 - "
3	Director		Usual Residence of Decedent		JULY 30,	1920   Pennsylvania
	Maryland -f show		10a. State 10b. County 10c. City, Town or L	ocation		10d. Inside City Limits
		tor	MD Queen Annes Stevensvi	lle		1 □ Yes Ž∕⊡ No
	death with the Maryla ms 23a or 28a-f shov f.i. wat be notified at	Funeral Director	10e. Street and Number 303 South Carolina Road	10f. Zip Code 21666	10g	, Citizen of What Country? USA
5-0036	after des or Itams	þ	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 ☒ Yes 2 □ No I☒ Yes, Give Coast Grd.	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2X No Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
2-0	"natural",	sted	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Give	dent's Usual Occupation	ring 16	b. Kind of Business/Industry
2121	within 900.	Completed		kind of work done during most of work DO NOT use retired) DNStruction	S	tate of
7	led w lygier her th		12 2 Tr	spection Manager		ennsylvania
ano	I be fi	Be	Bartholomew Stack	Ella	e (First, Middle, Ma	Stack
Maryland	12 should be filed within 'n and Mental Hygiene. 7 is marked other than "'traumatic evant, Ite Me	ပ		ng Address (Street and Number or Rur	al Route Number C	
Ma	nd 2 s ith an 27 is r trau			Ponderosa Drive,		
ē,	of Health of Health itam 27 I		20a. Method of Disposition 20b. Place of Disposition			c. Location - City or Town, State
Ë	Page ento nt: # ry or			dge Mem. Pk. 4/2]	_/2005 E	Elkridge, MD
Baltimore,	permit. Page Department o Important: If any injury or once.		21. Signature of Funeral Service Locksee	2. Name and Address of Facility Ary L. Kaufman Fun 250 Washington Blv	eral Home	@ Meadowridge MP, Inc. dge, MD 21075
			23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	<del></del>		
	Pnysician		Immediate Cause (Final disease or condition Atherosclerotic Cause or condition	ardiovascular Disc	200	Onset and Death
	/Medical		resulting in death)  a.   ACHETOSCIETOCIC  Due to (or as a consequence of):	ardiovascular Dise	ase	
	Examiner		Sequentially list conditions b.			
	및 ·∺	iner	Sequentially list conditions, if any, leading to immediate auss. Entar Underlying Cause (Disease or injury			
	ecute and trans	Examiner	Cause (Disease of Injury that initiated events resulting in death) Last C. Due to (or as a consequence of):			
8760,	be execut sician and burial-tran	E	out to (or as a consequence or).			
687	certificate iding physise as the	dica	d			
O. Box	the death y the atter ched for u	Physician/Medical		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
<u>ر</u> م	s that med b	by P	Part II. Other significant conditions contributing to death but not resulting in the to	nderlying cause given in Part I.	23e. Did tobac	cco use contribute to the cause of death?
ğ	w requires been sign should be	edk			1 ☐ Yes	2 ✓ o 3 ☐ Probably 4 ☐Unknown
Vital Records,	aw as b	Completed			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
- B	ate pag	mo.			performed	
/ita	ysician: The is certificate director, pag	Be (	25. Was case referred to medical examiner?		h (Check only one)	
of	Phys this al dii	၉	1 X'es 2 No Hospital: 1 □ Inpatient 2 □ ER/Outpatien	nt 3 DOA Other: 4 Nursing Ho		e 6 Other (Specify)
n C	ng fer inel	ion	27. Manner of Death 1	f 28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	28d. Describe how	injury occurred
Division	Attending r death. actor: After	Certification;	2 Accident investigation 3 Suicide 6 Could not be determined by the state of the st		28f. Location (Stree	et and Number or Rural Route Number.
Βį	after Dira	ertii	4 Homicide determined 288. Place of injury - Actionne, farm, st building, etc. (Specify)	out, motory, orroo	City or Town, S	State)
	To the Hospital or Attendi Within 24 hours after death. To tha Funeral Diractor: A completely filled in by the fu	Medical C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, deat 2 Medical Examiner: On the basis of examination and/or in and magnify stated.	h occurred at the time, date and place, vestigation, in my opinion, death occur	and due to the caus red at the time, date	se(s) and manner as stated. and place, and due to the cause(s)
	To th yo th compl	Me	29b. Signature and title of pertifier	29c. License number	29d.	Date signed (Month, Day, Year)
1			VA VI	OCME	A	PRIL 16, 2005
(1	88		30. Name and address of person who a implemed cause of death (Item 23a) (Type,	Print) 111 Penn Stree	et Baltin	more, Maryland 21201
	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature			
	Registi	- 8	APR 2 2 2005 Steam #	back		
Dir	MH 17 Rev 1/2	204	N LOUN JONES IN 19			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last) **GENEVA** 

SPRIGGS

2. Date of Death Month Yee 4PRI 2005

3. Time of Death 2138 PM

**Funeral** 

**Director** 28a-1 show the Medical Examiner must be notified at 238 or Items "natural",

Directo

and Mental Hygiene. or other traumatic event, nt of Health permit. Page Department of Important: If any injury or once.

21215-0036

Maryland

Baltimore,

P.O. Box 68760.

Division of Vital Records,

U

**Physician** /Medical Examiner

attending physician and for use as the burial-transit The law requires that the death certificate be executed the s been signed by the should be detach page 2 s certificate To the Hospital or Attending Physician: this nerel Director: After the filled in by the funeral death. within 24 hours after To the Funerel Direct

4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Baltimore NA Stella Maris-Mercy If Under 1 Year tf Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Days 1 ☐ M 2 🛛 F Yrs 216-62-4224 49 Md Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State X Yes 2 No Md. NA Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21213 2740 Mura Street Completed by Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-tf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 ☐ Married 1 ☐ Yes 2√∑ No Black Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) llth grade Disabled NA 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Singletary Corrine Brandon John ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Maiting Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2740 Mura Street, Baltimore, Md. Gloria Stokes Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State \* 4 ☐Donation 5 ☐Other (Specify) 4-25-05 Randallstown, Md. King Mem.Park 21. Signature of Funeral Service License 22. Name and Address of Facility 21202 Baltimore, Md. March F.H. East 1101 E. North Ave. Mens Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Finat disease or condition resulting in death) 9 Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. tf yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobaços use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 🗆 No 3 Probably 4 Unknown 24a. Was an ∕24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No autopsy 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) NOSPICE Hospitaf: 1 Yes 2P No 1 tnpatient 2 2 FR/Outnatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: fnjury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicat Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certific

State Registrar

Baldimore

30. Name and address of person who completed cause of death (ttem 23a) (Type, Print)

Riseberr

31. Date filed (Month, Day, Year)

			1 - State Registrar Co	partment of Health and Mental ertificate of Death	Hygiene 05 13735
ı	Physici	an	1. Decedent's Name (First, Middle, Last)	2. Date Mon	of Death th Day Year 3. Time of Death
	/Medic		Robert Charles Snyder		1 14, 2005 9:25 A M
	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
		4	Gilchrist Hopice Ctr.  5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	TOWSON  If Under 1 Year   If Under 24 Hrs.   8 Date	of Birth 9. Birthplace (State or Foreign
п	Funeral Director		216-32-3131 1 ★ 2□ F 69 Yrs.	Months Days Hours Min. (Mon	th, Day, Year) Country)
			Usual Residence of Decedent	OCt.	23,1935   Maryland
	nylan show	_	10a. State 10b. County 10c. City, Town or	Location	10d. Inside City Limits
	8a-f s	Director	Maryland Baltimore	Colgate	1 ☐ Yes 2⁄☐No
	vith th	Dire	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
	9ath 1	erai	7701 Wynbrook Road  11. Marital Status  12. Was Decedent Ever in U.S.  13. Marital Status	21224	United States
	iter d	Funerai	Armed Forces?	. Was Decedent of Hispanic Origin? (Specify Yes If Yes, specify Cuban, Mexican, Puerto Rican, et	or No- c.) 14. Race - American Indian, Black, White, etc.
93	urs a	by	1 □ Never Married 2 ☑ Married 1 ☑ Yes 2 □ No If Yes, Give 3 □ Widowed 4 □ Divorced Year or Dates:	1 ☐ Yes 2 【X No Specify:	Specify: White
2-0	72 ho	Completed	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Gi	edent's Usual Occupation	16b. Kind of Business/Industry
2	ithin 19.	npie	Elementary/Secondary (0-12) College (1-4or 5+)	e kind of work done during most of working DO NOT use retired)	
7	led w lygier har th	Š		Forces & Mail Carrier	U.S. Goverment
and	be fi	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, M	
Maryland 21215-0036	should be land Mental I smarkad o	٦	Charles Snyder  19a. Informant's Name/Relationship (Type, Print)  19b. Ma	Helen Baker	
Ma	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene.  If item 27 is marked othar than "natural", or items 23a or 28a-f show or other traumatic avant, the Mardical Eyan Latrinial Le notified at or other traumatic avant, the Mardical Eyan Latrinial Le notified at	) P	l i	iling Address <i>(Street and Number or Rural Route I</i> 27 Wallace Road Dunda	1k, Maryland 21222
ā,	permit. Pages 1 and 2 Dep ritment of Health a Important: If item 27 ii any injury or other tra		20a. Method of Disposition 20b. Place of Dis	position (Name of Date	20c. Location - City or Town, State
Baltimore,	Pages nent of P ant: If ite		1 - Bunar 2 Actemation 3 - Hemovar from State	ematory or other place)  Service Corp. 4/20/20	
₫	ortar ortar			22. Name and Address of Facility	
ñ	Department of the control of the con	i b	Vest 6 km	Duda-Ruck Funeral Home 7922 Wise Ave. Dunda	
			23a art1. Enter the disease, complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.		
E	Pnysician				Onset and Death
-	/Medical		resulting in death)  a	7001113	weeks
	Examiner		Immediate Cause (Final disease or condition resulting in death)  a. OSteom Due to (or as a consequence of):  Sequentially list conditions,	decubitus	mouths
	pa tis	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		
	and and I-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last  C. Due to (or as a consequence of):		
8760,	cate be executed physician and the burial-transit	aiE	Due to (of as a consequence of).		
387	icate phys s the	dicai	d		
Box (	leath certifica attending ph I for use as ti	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy		23d. Date of delivery
ă	death atte	iciai	in the past 12 months?  1 Ves 2 No 4 Pregnant at time of death 5	☐ Ectopic pregnancy ☐ Other (specify)	Month Day Year
о. О.	t the by the	hys	9 Unknown		
	The law requires that the death certific tte has been signed by the attending p page 2 should be detached for use as	by P	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I. 23e.	Did tobacco use contribute to the cause of death?
ord	w require been signature	led	end-Stage PAVICEN Sons	1) iscase	1 ☐ Yes 2 ☐No 3 ☐ Probably 4 ☐Unknown
ecc	e law n has be je 2 sh	pie	DiAbetes mellitus	24a.	Was an autopsy findings available prior to completion of cause of
Division of Vital Records,		Completed	covering Artery disease	10	performed? death?
/ita	Attending Physician: Th r death. ector: After this certificate by the funeral director, pag	Be (	25. Was case referred to medical examiner?	26. Place of Death (Check	only one)
of	Physi this o	<sup>L</sup>	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpat		Residence 6 NOther (Specify) (+ C 1 ) C
n	Jing I After funer	ion	27. Manner of Death 1 Death 28a. Date of Injury 28b. Time (Month, Day Year) Injury Injury	Work?	cribe how injury occurred
Sic	ittendi death. ctor: A the fu	ical	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm,		tion (Street and Number or Rural Route Number.
<u>≥</u>	al or Attending Phy after death. I Director: After this d in by the funeral d	Certification:	4 Homicide determined building, etc. (Specify)	City	or Town, State)
	To the Hospital or Attenwithin 24 hours after deatl To tha Funaral Director: completely filled in by the		29a. Certifier 1 Certifying Physician: To the best of my knowledge, de	ath occurred at the time, date and place, and due t	to the cause(s) and manner as stated.
	n 24 } n 24 } sa Fu	edicai	(Check only 2 Medical Examiner: On the basis of examination and/or one)	investigation, in my opinion, death occurred at the	time, date and place, and due to the cause(s)
	To the withing to the comp	Σ	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
			If Hother they a	D.75705	Agril 14, 2005
ندي	19		30. Name and address of person who completed cause of deam (II/ m 23a) (Typ	a, Print)	2 2.
דכ	1 1		30. Name and address of person who completed cause of deam (IV m 23a) (Typ W A R	101 M. Charles St	. Balto and 2120x
	Sta Registr	ite	31. Date filed (Month, Day, Year) 32. Register's Signature	Coarles	
2	negisti	ai,	THE PARTY OF THE PROPERTY OF T		

		_	For S1 1 - For Registrar	ate of Maryland		artment of H		Mental Hy	giene Reg. No.	05	13736
			Decedent's Name (First, Middle, Last)					2. Date of De	aath Day	Year	3. Time of Death
	Physicia /Medic		Calvin		Sh	aull		April	15	2005	8:20 AM
	Examin		4a. Facility Name (If not institution, give stree			4b. City, Town, or			4c. Co	unty of Death	
			Johns Hopkins Bayview	Medical Cen	fer	Baltime			N/.		
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. la.	st birthday)	Months Days	If Under 24 H	in. (Month, D.	ay, Year)		place (State or Foreign
	Director		214-26-8328	74_	Yrs.			July :	14, 19	30 Mar	yland
	and *	-	Usual Residence of Decedent  10a. State 10b. County	10c. City,	Town or Lo	cation				1	Od. Inside City Limits
	Aaryl f sho	ō	Maryland Baltimor	n Di	ındalk						1 ☐ Yes 2 🔀 No
	death with the Maryland	Director	10e. Street and Number		and I i	10f. Zip Code			10g. Citizer	n of What Cour	ntry?
	With With					27.22	2		Unit	ed Stat	.00
	death Ts 2	Funerai		Vas Decedent Ever in U.S	. 13.	Vas Decedent of H	ispanic Origin?	(Specify Yes or N		Race - Americ	an Indian,
	or Ite	F	1 Never Married 2 Married 1	Armed Forces? XXes 2 □ No fYes, Give	-	f Yes, specify Cuba 1 ☐ Yes 2 ☑ No	Specify:	ento micani, etc.)	Se	Black, White,	
3-003e	be filed within 72 hours after death with the Marylan de Hygiene.  Ide Hygiene.  Ide Hygiene.  Ide Hygiene.  Ide He Jical Examinar must be notified at event, Ital Me Jical Examinar must be notified at	d by	3 Widowed 4 Divorced	Year or Dates: Kore		7 2 7 2 7 4 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1				. , , , , ,	ite ——————
ה	72 h	Completed	15. Decedent's Education (Specify only highest grade con		(Give	dent's Usual Occup kind of work done	during most of v	working	16b. Kind	of Business/In	dustry
N	within 72 ene. than "net	mpi	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retired	3)			_	
N	filed v Hygie other t		8 years 17. Father's Name (First, Middle, Last)		Stee	lworker	18. Mother's h	Name (First, Middle	Stee B. Maiden Su		
_	ntal hed of	Be	Herbert Shaull					ret Rue			
چ	2 should be and Mental is marked reumatic ev	2	19a. Informant's Name/Relationship (Type,	Print)	19b. Mailir	ng Address (Street			ber, City or To	own, State, Zip	Code)
<u>8</u>	d 2 s th an treu										
ē,	Heal Heal tem 2		Bruce Belcher (Nephe 20a. Method of Disposition	20b. Pla	ce of Dispo	Cornwal sition (Name of matory or other place		Dunda 11 Date		yland 2 fion - City or To	
<u>o</u>	ages ant of it: If i		1 ☐ Burial 2 ☐ Cremation 3 ☐ Remo 4 ☐ Donation 5 ☐ Other (Specify)	oval from State		Service (	1	/18/2005	ТОМ	son, Ma	ryland
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Importent: If item 27 is marked ery injury or other treumatic evonce.		21. Signature of Funeral Service Licensee	22	22	2. Name and Addre	ss of Facility				
ñ	Dep Per		> Sto Dance 1	Yasselt	D 7	uda-Ruck 922 Wise	Funeral	l Home of	Dunda	alk, In	.C.
	, u.		23a. Part1. Enter the disease, or complication shock, or heart failure. List only one complications are complicated as the complex of the com	ons that caused the death.	Do not ent	er the mode of dyin	ng, such as card	liac or respiratory	arrest,	y Land	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		Hem	orrhage					Onset and Death
	/Medical		resulting in death)	Pulmonary Due to (or as a conseque	ence of):	Jerrenge					
	Examiner		Sequentially list conditions b. —								
	D #	iner	if any, leading to immediate cause. Enter Underlying	Due to (or as a conseque	ence of):						
	ecute and trans	Examiner	Cause (Disease or injury that initiated events c resulting in death) Last	Due to (or as a conseque	ance of):						
760,	ate be executed hysician and the burial-transit	cai E		Dao to (or as a consequ	01.00 017.						
	physics the	=	d								
×	death certificat e attending phy od for use as th	Physician/Med	IF FEMALE: 23c. 23c.	If yes, outcome of pregnan					230	d. Date of deliv	ery
Box	death a atter	ciar	in the past 12 months?	1 ☐ Live birth 2 ☐ Fetel = 4 ☐ Pregnant at time of de		_lEctopic pregnancy _] Other (specify)	y 			Month	Day Year
o.	res that the de igned by the a be detached f	hys	9 Unknown	9 Unknown							
Č,	s tha	by P	Part II. Dther significant conditions contrib	uting to death but not resul	Iting in the u	nderlying cause giv	en in Part I.				he cause of death?
ğ	w require been signated should b		Lung Cancer		-			- 1	Yes 2 l	No 3 X Pro	pably 4 □Unknown
Records,	a SC	Completed	J					_ 24a. Wa auto	s an 2	24b. Were auto prior to co	ppsy findings available impletion of cause of
		Son						per 1 □ Yes	formed? 2 No	death?	2)Q"No
/ita	ysicien: The l is certificate ha director, page	Be	25. Was case referred to medical examiner?			-		Death (Check only	one)		
1	Physicien: r this certificatal director, i	2	1 ☐ Yes 2 ₹ No Hosp	172 Inpatient 2 LE	28b. Time o		4   Nursin	g Home 5 Res			fy)
N N	Attending Pher death. rector: After the by the funeral	lon	1 Matural 5 ☐ Pending	(Month, Day Year)	Injury	Wo	rk?  Yes 2 No	200. Doscribe	, now injury o	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
S	or Attending after death. Director: After in by the fune.	icat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At ho	me, farm, st					Number or Run	al Route Number,
Division of Vital	after Direct	Certification:	4 Homicide determined	building, etc. (Specify,	)			City or To	оwп, State)		
_	spite nours nerel		29a. Certifier 1 Certifying Physici	an: To the best of my know	vledge, deat	th occurred at the ti	me, date and pl	ace, and due to the	e cause(s) ar	nd manner as	stated.
	To the Hospitel or within 24 hours after To the Funerel Dir completely filled in	edicai	(Check only 2 Medical Examiner one)	On the basis of examinati and manner stated.	ion and/or in	ivestigation, in my o	opinion, death o	ccurred at the time	, date and pl	ace, and due t	o the cause(s)
	To the To the Comp	Σ	29b. Signature and title of certifier			29c. Licens			29d. Date s	signed (Month,	Day, Year)
)	- /		Pwingmo			RES	-000		April	15, 2	2005
7	417		30. Name and address of person who comp			4 3	44 -	2 1221			
			Peter Wung 4940 Ed 31. Date filed (Month, Day, Year)	13 Begistrate Signat	e S	altimore	MD	21224			
	St Regist	ate rar	ADD 9 9	32. Registrate Signat	K	Engels)	5				
			MENGA	CHANGE	1 30						

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Mon 2005 /Medical 4a. Facility Name (If not institution, give street and number)

LOFUS FLOTEIN SYMYVIEW REEDICALC 4b. City, Town, or Location of Death SALTIVENE CITY **Examiner** If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 M 2 F 65 Director Oct. 4, 1939 Mary1and Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 27 Is marked other than "netural", or Items 23a or 28a-f show traumatic event, the Medical Examinar must be molified at Directo 1 Yes ZNO Maryland Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2731 Moorgate Road 21222 United States
14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status s 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify. ģ 3 Widowed 4 Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 years Business Office Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Severno Corradi Mary Esposito 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gerald Staskowiak (Husband) 2731 Moorgate Road Dundalk, Maryland 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1XDBurial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Deportment of Important: If any njury or once. ' 4 ☐ Donation 5 ☐ Other (Specify) St. Stanislaus Cemetery 4/21/2005 Baltimore, Maryland 21. Signature in Fineral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Avenue Dundalk, Maryland 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SHOCK Physician /Medical **Examiner** Sequentially list conditions, it is a leading to innectate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed the burial-transit and Box 68760 attending physician Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the at d be detached fo ☐Yes 2 No Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 1 ☐ Yes 2 ☐ No 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? Yes 2 No certificate 1 Yes Division of Vital To the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 1 Yes 2 □ No 1 Inpatient 2 X ER/Outpatient 3□ DOA After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No s after death 2 Accident 6 Could not be determined 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

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completely filled i \*\*Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated 29b. Signature and title of 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MEDICINE. JOHNS HOPLING PAYVIEW MEY. CTR. GIORGIO GALEINO 31. Date filed (Month, Day Year) 2005 Registrar's Signature Coaste State Registrar

For Amend Item//19a State Off Manage 1/22 postment of Health and Mental Hygiene Registrar Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day 14 **Physician** 9:50 PM egory pril 2005 /Medical 4a. Facility Name If not institution, give street and number; 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Hospital of Backmore City Balhmure Jinai If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth Month, Day, 5. Social Security Number Birthplace (State or Foreign **Funeral** Months Days Hours Min 212-94-4208 Usual Residence of Decedent 1 M 2□ F Director the Maryland 10b. County 10c. City. Town or Location 10d. Inside City Limits 10a, State or 28a-f shov traumatic event, the Medical Examiner must be notified at Maryland 1 No 2 No Completed by Funeral Director mol10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 ☐ Married ō If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced "naturei" 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry d 2 should be filed within 7 th and Mental Hygiene. 7 is marked other then "r Elementary/Secondary (0-12) College (1-4or 5+) X 18. Mother's Name (First, Middle, Maiden Surname 17. Father's Name (First, Middle, Last) Be . Pages 1 and 2 should be ment of Health and Menta tant: if Item 27 is marked Wayman aine manwillbur Wayman Sr. (Father) 19b. Mailing Address Street and Number or Rural Route Number, City or Town, 20b. Place of Disposition (Name of pemetery, crematory or other place) White e permit. Pages 1 and Department of Healt Important: if item 2' eny Injury or other 20026. other Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State 9 Voodlawn <sup>4</sup> □ Donation 5 □ Other (Specify) Cem. 21. Signature of Funeral Service Licensee 2. Name and Address of Facility Funeral Ve. Ba Home Ave. W. North 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart faillire. List only one cause on each line. **Approximate** Interval Between Onset and Death Immediate Cause (Final Hyper Kalenna **Physician** disease or condition resulting in death) /Medical Stage Examiner Esquentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospitel or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of) attending physician Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4 Pregnant at time of death 5 Other (specify) P.O. the 9☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ Division of Vital Records, 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an autopsy performed: 1 ☐ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Impatient Certification: To 2 ER/Outpatient 3 DOA this 27. Manner of Death 1 Matural 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident after death 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide 24 hours a Punerel [ 1 Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier within 24 ho To the Fune completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 2

State

Known A

31. Date filed (Month, Day, Year) Registrar

2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ALDEN (7. PEOPUS 2401 M. BELVEDERE 2401 W. BELVEDERE gistrar's Signatur

mo P50693

AVE.

April 20, 2005

BALTIMORE MD 21215

			State of Maryland / Department of Health a		ene	
			1 - State Registrar Certificate of Death	Re 2. Date of Death	g. No. 2015	13739
	Physicia	an	1. Decedent's Name (First, Middle, Last)	Month 4/18/	Day Year	9:30 A M
	/Medic Examin		Lewis George Woodland  4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location		4c. County of Death	1
			Civista Medical Center LAPlata		Charles	S
	Funeral Director		5. Social Security Number  6. Sex 1 1 2 M 2 F 7. Age (In yrs. last birthday) If Under 1 Year If Under 1 Year Hours  7. Age (In yrs. last birthday) Yrs. Months Days Hours	Min. 8. Date of Birth (Month, Day,	Year) Con	nplace (State or Foreign untry)
	ō.		Usual Residence of Decedent	CORUME	43,111	
	larylar show	ū	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits 1 ✓ Yes 2 ☐ No
	28a-f	Directo	Maryland St. Mary Charlotte Had	10	ng. Citizen of What Co	untry?
	th with 23a or 1st De	al DI	37546 SURVEISE LANE 20622		4.S. A	
	er dea	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Or If Yes, specify Cuban, Mexican	rigin? (Specify Yes or No- n, Puerto Rican, etc.)	14. Race - Ame Black, White	
936	be filad within 72 hours after death with the Maryland that Hygiene. ad other than "natural", or Itams 23a or 28a-f show other than "natural", or Itams 20a or 28a-f show event. The Medical Estandard must be notified at	by F	1 Never Married 2 Married 1 16 Yes 2 No If Yes, Give 1 Yes 2 1 No Specify: Year or Dates:	•	Specify: B	eck
5-0036	72 ho	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during mos	st of working	16b. Kind of Business/	Industry
2121	within ene. than "	dmo	Elementary/Secondary (0-12) College (1-4or 5+)	1	Edson (	THEMMISYOF
and 2	e filad Il Hygi other	Be Co	17. Father's Name (First, Middle, Last)  18. Mother	er's Name (First, Middle, M		O TCT TO TO
ylar	2 should be filad within and Mental Hygiene. is markad other than aumatic event. Its M	To	SIGNEY G. WOODLAND HO	NES F. FOR	d	
Maryl			19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Numb  19b. Mailing Address (Street and Numb  9 Dunmore Court	LILL CM	1 1 2	ip Code)
-	s 1 and f Health item 27 other tr		20a. Method of Disposition 20b. Place of Disposition (Name of		20c. Location - City or	Town, State
imo	<b>6</b> 0		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  4 ☐ Donation 5 ☐ Other (Specify)	April 25,2005	Cheltent	am mo
Baltimore	permit. Pag Department Important: I any injury o		21. Signature of the heral Service Lifense 22. Name and Address of Facility	III DA	No.	WN
	48244		23a, Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as	s cerdiac or respiratory arre	est,	Approximate Interval Between
	Pnysician		shock, or heartifailure. List only one cause on each line.  Immediate Cause (Final disease or condition SUDIEN CARDIAC DE	EATH		Onset and Death
1	/Medical Examiner		resulting in death)  Due to (or as a consequence of):	DISEASE		YI NR S
	Examiner	io io	Esquentially like conditions, if any, leading to immediate  Due to (or as a consequence of):	VISLASL	-	1641)
	cutad id ansit	Examiner	Esquentially liet conditione, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events.)  DIABETES MELLITUS			YEARS
,00	ate ba exacutad		resulting in death) Last  Due to (or as a consequence of):  HYPERTANSION			YEARS
68760	icate t	edical	0.			
Вох	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy		23d. Date of deli	ivery Day Year
Ю. В	ne deat the att hed fo	sicla	in the past 12 months?  1  Yes 2  No 9  Unknown		Month	Day 1 Gai
٥.	ires that the de signed by the a I be detached f	y Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part	I. 23e. Did tob	acco use contribute to	the cause of death?
rds	w requires baen sign should be	ed by		1 □ Ye	s 2□No 3□Pr	obably 4 Onknown
Records,	law requias baen a 2 shouk	Completed		24a. Was ar autops	24b. Were au prior to d	stopsy findings available completion of cause of
	t: The icate h r, page			perform 1 Yes	No 1 Yes	2 🗆 No
V.	/siciar s certif diracto	To Be	examiner?	e of Death (Check only one lursing Home 5 Reside		cify)
n of	ng Phy ter thi	T :uc			w injury occurred	
Division of Vital	Attanding Physician: r death. sctor: After this certifics by the funeral diractor.	Certification;	2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office		reet and Number or Ru	ural Route Number.
Divi	ater after I Dirac	ertif	4 Homicide determined determined building, etc. (Specify)	City or Town		
	To the Hospital or Attanding Physicien: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	calC	29a. Certifier  (Check only (C	and place, and due to the ca	ause(s) and manner as	stated. to the cause(s)
	To the H within 24 To the F complete	Medical	one) and manner stated.  29b. Signature and title of certifier 29c. License number		9d. Date signed (Monti	
	F 3 F 8	2	Denty Shah AND FACC D405	793	4 190	5
1	1		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	141) /1	11/2 20	5/ C=N
T mil	) '		De. Anil K. Shah 26840 Pt. Lockout Kd. Suite 1  31. Date filed (Month, Day, Year)  32. Registrar's Signature	101 LEONARdto	WN, MD 20	1630
	St: Regist	ate rar	Ame A			
DH	IMH 17 Rev 1/2	2001	APR 2 2 2005 Janua M. Spark			
			ORIGINAL			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend Item 28f per ME, G842, 04/21/05dhb Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 25 Neuro 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore
If Under 1 Year If Under 24 Hrs. H/mere 7. Age (In yrg. 5. Social Security Number 6. Sex gst birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 1 F Months Days Hours Min Yrs. 14. 64. 746 Usual Residence of Decedent Director 10b. County 10c. City, Town or Location 10a. State Item 27 is marked other than Trautien, or reme and a continual te notified at other traumatic event, the Medical Evanther must be notified at 1 Yes 2 No Completed by Funeral Director DACTIMOXE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21201 Itema 23a 2 should be filed within 72 hours after death and Mental Hygiene. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No DLACK 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DONOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry at Hygiene. condary (0-12) Elementary/Ser College (1-4or 5+) PHLEBOTOMIS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Su To Be AVMOND 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, BACTIMORE, MD ethod of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Depertment o Important: If any Injury or once. ^ 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee C. GREENE FUNERALITAME BATIMOKE, MO 21212 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest ist only one cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or comshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Physician gunation CASan /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence,of) Examiner the burial-transit Diabetes ON APPROVED BY MEDICAL EXAMINER Due to (or as a consequence of) Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregr 5 ☐ Other (eggen) in the past 12 months?

1 Yes 2 No
9 Unknown ģ Month Year 4☐Pregnant at time of death à signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 214 No 1 Yes Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending Pt. exsangunated for ruptu 2 Accident 3 Suicide investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify). Director: Could not be determined 28f. Location (Street and Number or Rura City or Town, State) Owlings 4 Thomicide 11767 Owings Mills within 24 hours a To the Funeral I 1/ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License numbe **D** 56266 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier ans mo 2005

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Carol Anne St. Louis, North est Hosp Randallstown, MD

31. Date filed (Month, Day, Year)

Registrar

#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** April Jarner 10:30 pm. /Medical 4a. Facility Name (If not institution, give street and number) 4b. Cify, Town, or Location of Death 4c. County of Death Examiner Long View Nursing Home Manchester Carroll 8. Date of Birth (Month, Day, Year) March If Under 1 Year Months Days If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Country) Mary Land 6. Sex **Funeral** Months 1□M 2 F Hours 215-20-9938 90 Yrs. Director Usual Residence of Decedent death with the Maryland 10c. City. Town or Location 10a. State 10b. County 10d. Inside City Limits show if Health and Mental Hygiene. Item 27 is marked other then "netural", or items 23s or 28e-f show other treumstic event, the Medical Examinat must be notified at Maryland Carroll Manchester 1 ☐ Yes 2 ☐ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2982 Park Ave. 21102 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: White à 3 Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College, (1-4or 5+) Housewife Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Cleon Bond Edna Almony ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health e important: if item 27 is any injury or other tre Mary Jane Graf - daughter 5115 Church St. Lineboro, Md. 21102 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Lineboro Cem. Inc. April 24,2005 Lineboro, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Eckhardt Funeral 3296 Charmil Dr. Chapel P.A. Manchester, Md. 21102 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical .000 Examiner Due to (or as e consequence of) Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Due to (or as a consequence of): Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown ģ 24b. Were eutopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 28c. Injury et Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, within 24 hours effer death.

To the Funeral Director: After this certificate has been signed by the a completely filled in by the funeral director, page 2 should be deteched Hospitai

a w 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2 ever nlew 31. Date filed (Month, Day, Year) State APR 2 2 2005 Registrar

4 Homicide

(Check only one)

29b. Signature and title of certifier

29a. Certifier

Medical

gistrar's Signature

1))

Destrifying Physiclen: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

3 (6

29d. Date signed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - Stata Registrar Certificate of Death Rag. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 17<sup>Day</sup> **Physician** Month 4 2005 Ella Yarborough 8:45p /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Good Samaritan N.H. Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Min. 1 ☐ M 2 € F Director Yrs. 212-18-9271 86 5-1-18 Md Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 27 is marked other than "neturei", or items 23a or 28a-f show traumatic event, the Madical Examinar must be notified at Director Md. NA Baltimore X□Yes 2□No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? be filed within 72 hours after death with 5010 Sipple Avenue 21206 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Yes 2 No Black Specify: 3X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12th grade 17. Father's Name (First, Middle, Last) Beautician Varies 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be nent of Health and Mental is marked 2 Pindell Phillip Mary White 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i 5017 Yellowwood Rd., Baltimore, Md. Michael Guye Son other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages Department of I Important: If it eny injury or o once. 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Baltimore National Cem. 4-22-05 Baltimore, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Baltimore, Md. 21202 1101 E. North Ave. March F.H. East 23a. P. rt1. Enter the disease, or complicating that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ray e on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 20 greens /Medical Due to (or as a construence of). Examiner Sequentially list conditions, any, leading to minediate cause. Enter Underlying Cause (Disease or injury 2000 Due to (or as a consequence of) Examiner use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last signed by the attending physician and d be detached for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Contra inth 1 Yes 2 No 3 Probably peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has this certificate 1 ☐ Yes 2 No 2 🗆 No 1 Yes or Attending Physicien: director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 2 ER/Outpatient 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 1 🗌 Inpatient 3□ DQA uneral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: completely filled in by the I 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel I 1 Crtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) WZ D 31464 4/21/05 MID

State Registrar

31. Date filed (Month, Day, Year) APR 22 2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Pnnt)

HASHM1

ENTAW ST SMR 308 32. Registrar's Signature

Bally, MDZ120

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

MD

O. Box 68760,
Records, P.
vision of Vital

		For State (	of Maryland	-	irtment of <i>tificate o</i>				leg. No:	5 1374	
Physici /Medic		Decedent's Name (First, Middle, Last)     LORETTA M. ZAKROCZ	YNSKI					Date of Dea Month	Day	Year 9:13	
Examin		4a. Facility Name (If not institution, give street and n MERCY HOSPITAL HOSPI			4b. City, Town BALT	or Location			4c. County of		
Funeral Director		5. Social Security Number 6. Sex 1 M 2/1 F	7. Age (In yrs. last	t birthday) Yrs.	If Under 1 Yea Months Day			Date of Birth Month, Day LY 22	, Year) 1920	9. Birthplace (State or For Country) MD.	
Maryland f show	or	Usual Residence of Decedent  10a. Slate 10b. County  MD • N/A	10c. City, T		cation					10d. Inside City Lin 1 ☑ Yes 2 ☐	
with the 3a or 28e-	Funeral Director	10e. Street and Number 330 IMLA STREET		DAL.	10f. Zip Code	2122	24		10g. Citizen of What Country? UNITED STATES		
should be filed within 72 hours after death with the Maryland nd Mental Hygiene. I marked other then "neturet", or ttems 23a or 28e-f show umatic event. I'm Meulcal Extraffication in the could be a marked or the could be a marked to the could be	þ	11. Marital Status 12. Was De Armed F	cedent Ever in U.S. Forces? 27 No Sive A Dates:		Vas Decedent of Yes, specify Ci			Yes or No- in, etc.)	14. Race Black Specify:	- American Indian, , White, etc. WHITE	
i within 72 hou liene. r then "neture	Completed	15. Decedent's Education (Specify only highest grade completed Elementary/Secondary (0-12) 8TH College	(1-4or 5+)	(Give life. l	lent's Usual Occ kind of work dor OO NOT use reti HOMEMAKI	ne during mos ired)	st of working		16b. Kind of Bus	,	
id be filed withi lental Hygiene. ked other then ic event, the M	To Be Co	17. Father's Name (First, Middle, Last)  JOHN WELSH					er's Name <i>(Fil</i> ANCES V		Maiden Sumame MS	)	
nd 2 lith a 27 ts		19a. Informant's Name/Relationship (Type, Print) DOLORES SHARNAS/DAUGHTEI							r, City or Town, S IARYLAND		
t. Page rtment o rtent: If		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from  4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Licensee	n State cem	etery, cren CIMOR	sition (Name of natory or other p E NATIOI . Name and Ado	NAL	Date 4/21/C		BALTIMOR	City or Town, State RE, MARYLAND & SON, INC.	
Dermi Depa Impo any ir		23a Part 1. Errer the disease or complications that	caused the death	6	224 EAS	ΓERN A	VE., BA	LTIMC	RE, MARY	YLAND 21224 Approximate	
Pn <del>ysicia</del> n /Medical Examiner			each line.  Chronic  of or as a consequen	ره						Interval Betweer Onset and Deat	
te be ysicia ie bur	Ical Examiner	Cause (Disease or injury that initiated events c.	o (or as a consequer								
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w requires tha been signed I should be det		Part II. Other significant conditions contributing to	death but not resultin	ng in the ui	nderlying cause	given in Part	l. 	/	•	bute to the cause of death  3 Probably 4 Unkn	
The law re ate has be page 2 sho	Completed							24a. Was a autop perfor	sy pr med? de	fere autopsy findings avail rior to completion of cause eath? □ Yes 2□ No	
ftei	To Be	27. Manper of Death 28a. Dale	111111	VOutpatien Bb. Time of Injury	28c. In	Other: 4 N	28d.	5 🗆 Resid	ne) lence 6 Bother ow injury occurre	1569	
te Hospitel or Attendi 24 hours after death. te Funcel Director: A Netely filled in by the t	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Plate buil	ce of Injury - At home ding, etc. (Specify)	e, farm, str	eet, factory, offic	e .	28f.	Location (S City or Tow		r or Rural Route Number,	
To the Hospit within 24 hour To the Funer completely fill	Medical		ne best of my knowle basis of examination nner stated.	edge, death and/or inv	vestigation, in m	y opinion, dea	nd place, and ath occurred a	it the time, o	date and place, ar	nd due to the cause(s)	
To Twith	2	29b. Signature and title of certifier	Iso of doorh //in-	79) /T	Di	1085°	-1			(Month, Day, Year)	
Sta	te.	30. Name and address of person who completed car  Rischerg  31. Date filed (Month, Day, Year)	301 5	I PC	19 1US	Bal	Limore	ma	d. 212	02	
Registra		APR 2 2 2005	Elemen .	K A	posts						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 4 Month 2. Date of Death Day Yeer **Physician** 10:36A 2005 Dolores Arthur Brown /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner If Under 1 Year If Under 24
Months Days Prince George s

9. Birthplace (State or Foreign Country) Doctors Hospital 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Min. 1 □ M 2 X F Yrs Director 579-50-8214 70 15, 1934 Wash., DC Usual Residence of Decedent Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f shov traumatic event, the Medical Examinar must be notified at 1 XYes 2 No Prince George's Springdale Maryland Directo the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Kit. ō Items 23a 3630 Cousins Drive 20774 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White Pican filed within 72 hours after ☐Yes 2☐No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ŏ 1 ☐ Yes 2 ☐ No Specify: If Yes, Give Year or Dates: Specify: Completed by American 3 ₩idowed 4 Divorced "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry d 2 should be filed within in and Mental Hygiene.
7 is marked other than "r College (1-4or 5+) Elementary/Secondary (0-12) Supervisory Survey Statistician Government 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Roxey S. Swann Louis A. Arthur ٩ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health an permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other tra once. 12001 Shadystone Terr., Mitchellville, MD 20721 DeNaye D. Brown - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Ft. Lincoln Cemetery 4/14/2005 Brentwood, MD \* 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Stewart Funeral Home 21. Signature of Juneral Service Licen is own). 4001 Benning Rd., N.E. Wash., DC 20019 23a. Part1. E er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or eart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or conduion resulting in death) Physician MULTI- ORGAN FAILURE /Medical Due to (or as a consequence of) Examiner BREAST CANCER METASTATIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed use as the burial-transit LUNG METASTASIS resulting in death) Last Due to (or as a consequence of) P.O. Box 68760. LIVER METASTASIS Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) the 9 Unknown Š Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Be Completed by sign be BONE METASTASIS 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? page 2 1 Yes ral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After funer 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A investigation 2 Accident the 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospital 1x Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29h. Signature and title of certifier 7/05 D43162 Expus, mo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MELVIN GASKINS, MD 7831 BELLE FOINT DR. GREENBELT, MD

State Registrar

32. Registrar's Signature

DHMH 17 Rev 1/200

31. Date filed (Month, Day, Year)
APR 1 1 2005

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	Physici	an	Decedent's Name (First, Middle, La     Bruce T.					2. Date of Dea		Year 3. Time		
	/Medic		4a. Facility Name (If not institution, giv			4b. City, Town,	or Location of Death	Abrit	4c. County		љ	
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	Funeral Director		577–11–1265	Sex 7. Ag	e (In yrs. last birthday, 20 Yrs.	If Under 1 Year Months Days		8. Date of Birth (Month, Day July 3,	v. 1984	9. Birthplace (State Country) Washington	or Foreign 1, D.C.	
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside	City Limits	
	should be filed within 72 hours after death with the Maryland And Mental Hygiene. In Mental Hygiene, and I will he was a constant of the hear and the hear and the hear and the restlined and the second of the hear and the restlined and the second of the s	ector	D.C.			Wash	nington		10g. Citizen of		s 2 No	
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10	ter death	Completed by Funeral Director	11. Marital Status  1 XX ever Married 2 ☐ Married	12. Was Decedent Armed Forces? 1 ☐ Yes 2 🔀			Hispanic Origin? (Spenar, Mexican, Puerto	ecify Yes or No- Rican, etc.)	Bla	ce - American Indian, ck, White, etc.		
Maryland 21215-0036	nours aft	d by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 XXXVo				y: Black		
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	od 2 Ith a 27 is		19a. Informant's Name/Relationship (Mc	ther) ' 	1490	Columbia B	each Road Sh	adyside,	Maryland	20764		
Baltimore,	% O		20a. Method of Disposition  1 → Burial 2 □ Cremation 3 □  1 □ Donation 5 □ Other (Speci	Removal from State	20b. Place of Disp cemetery, cre		TADE LE	13, 2005		City or Town, State		
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P.O. Box 6	To the Hospital or Attanding Physician: The law requires that the death certificate within 24 hours after death.  To the Funarel Diractor: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the	Physiclan/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal death 3	⊒Ectopic pregnand ☐ Other (specify) _	зу			ate of delivery onth Day	Year	
	ires that signed b	by	Part II. Other significant conditions	contributing to death b	out not resulting in the i	underlying cause g	iven in Part I.	23e. Did to	~	tribute to the cause of		
Division of Vital Records,	The taw requir cate has been si	Completed						24a. Was autop perfo	an 24b.	Were autopsy finding prior to completion of death?	s available cause of	
Vit	ysician: The is certificate hi director, page	o Be	25. Was case referred to medical examiner?   ↑★ Yes 2 □ No	Hospital: 1 🔲 Inpatio	ent 2 ER/Outpatie	nt 3 DOA	26. Place of Deatl ther: 4 \(\sum \) Nursing Ho			ner (Specily) At S	Scene	
<u>5</u>	ding Phy h. After thi funeral	on: T	27. Manner of Death 1 □Natural 5 □ Pending	28a. Date of Inju (Month, Da	y Year) Injury	of 28c. Inju	ury at ork?	28d. Describe h	now injury occur		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
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	Hospit 4 hours Funare ely fille	edical (	(Check only Medical Exa	minar: On the basis of	of my knowledge, dea of examination and/or in	th occurred at the to	time, date and place, opinion, death occur	and due to the dead at the time,	cause(s and m date and place,	anner as stated. and due to the cause	(s)	
	To the I within 2 To the I	Med	29b. Signature at 4 title (1 ce) lifte	and marrier at		29c. Licen	ise number		29d. Date signe	ed (Month, Day, Year)		
	0		30. Name and address of person who	completed cause of	death (Item 23a) (Type		OT 117		April	6, 2005		
Y			XXHO	54N			enn Street	: Balti	more, N	Maryland 21	1201	
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) APR 1 1 2005	32, Registi	rar's Signature	B						

DHMH 17 Rev 1/2001

Maurice Antonio Brown Unknown 05-02378

Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** MAURICE ANTONIO BROWN April 5 2005 01:03 A. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 8101 Allendale Road (front of) Landover Prince George's If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 981 9. Birthplace (State or Foreign Country) 6. Sex **Funeral** Months 1⊠M 2□F Director 23 September 24 Maryland 213-98-1523 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State or 28a-f show other traumatic event, the Medical Examiner must be notified at tx Yes 2 □ No Director Prince Geoege's Capitol Heights 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code or items 23a U.S.A. 20743 1313 Karen Blvd Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 XI If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married 2 No 1 ☐ Yes 2 🛛 No Specify: Specify by 3 Widowed 4 Divorced Black "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Complet 12 should be filed within 7 h and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) Private 11th Laborer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Maurice J. Edwards Sherri R. Brown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 st Department of Health and Important: If item 27 is n any injury or other traur 8433 Hamlin Street # 303 Glenarden, Maryland 20706 Sherri R. Brown/Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ⊠ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 4/13/05 Washington, DC Mt. Olivet 21. Signatura di Funeral Service Licensce 22. Name and Address of Facility J. B. Jenkins Funeral Home 7474 Landover Road Landover, Maryland 20785 23a. Part 1. Enter the disease, or complications that caosed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician Wounds shot /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner sician and burial-transit The law requires that the death certificate be exec Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 4□Pregnant at time of death the 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 X Yes 2 □ No has 1 Yes 2 🗆 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence (Specify) At scene 2 1X Yes 2 □ No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Certification: After Injury 1 Natural 5 Pending 102 M Subject Shot after death. 1 Yes 2 No 415/05 investigation 2 Accident MM Location (Street and Number or Rural Route Number, City or Town, State) 8131 Allender Road 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Landover, Maryland within 24 hours a To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and trial mediated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier OCME April 5, 2005

Division of Vital Records, P.O. Box 68760

THE ODORE MILE, 31. Date filed (Month, Day, Year, APR 1 1 2005

32. Registrar's Signature

ans

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

111 Penn Street Baltimore, Maryland 21201

			For	State of Maryland /	Depa	artment of H	lealth and M	-	-	ne.	(") erg } erg	
_			1 - State Registrar		Cer	tificate of	Death		eg. No: UU	C	3/4/	
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	or 28	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of W	hat Country?	?	
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au	d be ental ked c	To Be	WILLIAM RUSSEI	L BUCHANAN			GLADYS	Τ. Τ Τ. Τ. Τ Δ	N WEEK			
Maryland	should by nd Menta marked	-	19a. Informant's Name/Relationship (	City or Town, State, Zip Code)								
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Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Importent: If item 27 Is marked any injury or other treumetic ex		20a. Method of Disposition	20b. Place o	f Dispos	sition (Name of patory or other place				c. Location - City or Town, State		
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m	Department Department		Mulul	O. Kann	BA		FUNERAL					
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Р. О.	he de r the	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown	2	Other (specify)						
	ires that the de signed by the a l be detached f		Part II. Other significant conditions of	ontributing to death but not resulting in	n the un	derlying cause give	en in Part I.	23e. Did tob	acco use contrib	oute to the ca	ause of death?	
ds,	uires sign ld be	d by		/ ///	رو			1 ☐ Ye	s 2 No 3	Probably	4 Unknown	
Records,	w require been signature	Completed						24a. Was ar	24b W	are autopey	findings available	
Re	he la e has	шс	,					autopsy	ned2 pri de	or to comple ath?	etion of cause of	
	ification, pe	e C	25. Was case referred to medical				00 81 (8 4			Yes 2□	No	
Division of Vital	Attending Physicien: The law requires that the death certificate be executed ar death. rector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	o B	examiner?	Hospital: Inpatient 2 ER/Ou	ıtnatient	3□ DOA Othe	26. Place of Death er: 4 ☐ Nursing Hon			(Speciful		
0	g Phy erthi	$\vdash$	27. Manner of Death	28a. Date of Injury 28b.	Time of	28c. Injury Work	at 2	8d. Describe ho				
<u>Ö</u>	ath. r: Aft	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investigation		njury		k? Yes 2□No					
<u>Vis</u>		ific	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home, fa building, etc. (Specify)	ırm, stre	et, factory, office	2	8f. Location (Str. City or Town,		or Rural Ro	ute Number,	
	tel or A rs after el Direc ed in by	Certification:		building, etc. (Specify)				City of Town,	, State)			
	Hospitel or Atten 24 hours after deatl Funerel Director: tely filled in by the	cal	29a. Certifier Certifying Ph	ysician: To the best of my knowledge	, death	occurred at the tim	ne, date and place, a	nd due to the ca	use(s) and manr	ner as stated	1.	
	To the Hospitel or within 24 hours after To the Funerel Dirt completely filled in I	ledical	one)	niner: On the basis of examination an and manner stated.	- Invi			u at the time, da	ue and place, an	a due to the	cause(s)	
	To To	Σ	29b. Signature and title of certifier	$\sim 10^{-1}$	N	29c. License		29	d. Date signed (	Month, Day,	Year)	
			1 de	yell a	A	D-0	2975		4-15	-05		
	1111		30. Name and address of person who				C		1			
	11		Daniel M Howe 31. Date filed (Month, Day, Year)	11, MD 11345 P	emb	rooke S	q Ste 10	)4 Wald	lorf, M	D 206	603	
	Sta	tę 🖫	ΔPR 9 9 2005	J. Augistrar S Signature	medi	B						

DHMH 17 Rev 1/2001

Calvin Buchanon

			1 - For State Registrar	State of Ma	aryland	-	artment of rtificate of			-	giene Reg. No. ()	05	13748
	Physici /Medio		Decedent's Name (First, Middle, La     MARGARET E	st) LIZABETH B	ONE					2. Date of Dea	Day	Year	3. Time of Death
	Examir		4a. Facility Name (If not institution, gin Scienced Hear	+ Hospi			4b. City, Town,	berlo	and		All	inty of Death	"14
	Funeral Director		5. Social Security Number 6.3 217 28 9978 Usual Residence of Decedent	Sex 7. Age 1□M 2ÅF	72	est birthday) Yrs.	If Under 1 Yea Months Day		Min.	8. Date of Birt (Month, Da APRIL	y, <i>Year)</i> 30 193	9. Birth	place (State or Foreign intry)
	Maryland I-f show	tor	10a. State 10b. County  MARYLAND ALLEGAN	Y	10c. City	, Town or Lo		STBUR	G				10d. Inside City Limits  X☐ Yes 2 ☐ No
	with the	I Director	10e. Street and Number	Em			10f. Zip Code				10g. Citizen		intry?
036	urs after death al', or itams 2: Exa. dr et f. us	by Funeral	87 SPRING STRE  11. Marital Status  1 □ Never Married 2 □ Married  3X Widowed 4 □ Divorced	12. Was Decedent E Armed Forces 1 Tyes 2 H If Yes, Give Year or Dates:	Ever in U.S	'	Was Decedent of f Yes, specify Cu			cify Yes or No- Rican, etc.)	- 14. F	Race - Ameri Black, White	
21215-0036	permit Pagas 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department if item 27 is marked other than "natural", or Itams 23a or 28a-f show any injury or other traumatic event, Ita Madical Exacilitation and once.	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12) 1 2						st of workin	g		f Business/Ir	ndustry
Maryland 2		To Be C	17. Father's Name (First, Middle, Last  CARL DIECK							(First, Middle,		name)	
, Mar	and 2 shi alth and n 27 is m er traum		19a. Informant's Name/Relationship CINDY BITTINGER/	, ,			g Address (Stree SPRING S'						p Code)
Baltimore,	Pagas 1 annont of He ant: If item ary or othe		20a. Method of Disposition  1 Burial 2 Cremation 3 C  4 Donation 5 Other (Speci		ce	metery, cren	sition (Name of natory or other pl MEMORIA	1	4/1	.5/05	20c. Location		own, State URG, MD
Balti	permit Departn Importe any in L		21. Signature of Funeral Service Licensee 22. Name and Address of Facility 60 W. MAIN STREET SOWERS FUNERAL HOME, P.A. FROSTBURG, MD 21532										
	Physician		23a. Pañ1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that caused one cause on each line a.	е.					rest,		Approximate Interval Between Onset and Death	
ď	/Medical Examiner			Due to (or as a ISCHE	M/C	ence of):	HEART AROID	MYOI	PATL	4			2 /v mm
V	ate be executad hysician and the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a									
68760,	ate hy:	edical	d										
.O. Box	The law requiras that the death certifica tle has been signed by the attending pl page 2 should be detached for use as I	Physician/Med	FFEMALE: 23b. Was decedent pregnant in the past 12 ppoinths?   1									Date of deliv Month	ery Day Year
Φ.	w requiras that been signed b should be deta		Part II. Other significant conditions of CHRONIC OBS	contributing to death bu			nderlying cause g	OIST	かき	23e. Did to	_		he cause of death?
Vital Records,		Completed by										prior to co death?	opsy findings available impletion of cause of 2 No
of Vit	hysician: this certifica al director, I	To Be	25. Was case referred to medical examiner?	Hospital: 1 Inpatier		R/Outpatien	1 3L DOA	ther: 4 🗆 Nu	ırsing Hom	(Check only or e 5 ☐ Resid	ence 6 🗆 C		(y)
Division of	ttending I death. ctor: After t the funer	Certification:	27. Manne of Death  1	e Con Diago of Injur	Year)		M 1 [	ork? ⊒Yes 2⊟	No	3d. Describe h  Bf. Location (S  City or Tow	treet and Nu		al Route Number,
	To the Hospital or A within 24 hours after To the Funeral Directompletely filled in by	edical	29a. Certifier  (Check only one)  1 Certifying Pl 2 Medical Exam	nysicien: To the best of miner: On the basis of and manner stat	examination	rledge, death on and/or inv	occurred at the restigation, in my	time, date an opinion, dea	id place, ar th occurred	nd due to the d d at the time, d	ause(s) and date and plac	manner as s e, and due to	stated. o the cause(s)
	To t To t	Σ	29b. Signature and title of certifier	my				nse number	73/		APRI		
	8		11 01 721	completed cause of de		23a) (Type, I 9/2	Print) SETV	NE	mev	E C	umB	rrian	10, mp200
	Sta Registr		31. Date filed (Month, Day, Year) APR 2 2 2005	32. Registra	r's Signatu	Cools							

				partment of Health and Nertificate of Death	Reg	ene No.2005 13749			
ı	Physic		1. Decedent's Name <i>(First, Middle, Last)</i> Margaret J. Brosnan		2. Date of Death Month April 3,	Day Year 2005 4:15 p M			
	/Medi Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	1-1-1-07	4c. County of Death			
			Suburban Hospital	Bethesda		Montgomery			
	Funeral Director		5. Social Security Number  216-14-1465  Usual Residence of Decedent  6. Sex 1 M 2 F 7. Age (In yrs. last birthday 7. Age (In y	If Under 1 Year   If Under 24 Hrs.   Months   Days   Hours   Min.	8. Date of Birth (Month, Day, Y March 1,	(ear) 9. Birthplace (State or Foreign Country) 1921 Maryland			
	Maryland a-f show	tor	10a State 10b. County 10c. City, Town or L Maryland Montgomery Ke	ocation ensington		10d. Inside City Limits 1 ☐ Yes 2 🎛 No			
	or 28	Director	10e. Street and Number	10f. Zip Code	10g	. Citizen of What Country?			
	s 23a	erai	5213 White Flint Drive	20895		USA			
920	permit. Pages 1 and 2 should be tiled within 72 hours atter death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itams 23e or 28e-1 show among myinty or other traumatic event, ire Medical Examine to use be notified at 900ce.	by Funeral	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Married 11. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Married 11. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☐ No Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: White			
21215-0036		Completed	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Give	edent's Usual Occupation a kind of work done during most of work DO NOT use retired)	ing 16	b. Kind of Business/Industry			
	liled w Hygier thar th		2 17. Father's Name (First, Middle, Last)	Nurse	- (First 16)-16	Medical			
Maryland	d Mental I	To Be	George Gunter	Jane	cameron				
	ulth an ulth ar traur			ing Address <i>(Street and Number or Run</i> 8 Buchanan Court,					
Baltimore,	Pages 1 arent of Hearnt: If itam		20a. Method of Disposition  20b. Place of Disposition  1 A Burial 2 Cremation 3 Removal from State	osition (Name of matory or other place)  Remorrial Park	Date 200	c. Location - City or Town, State			
2005 Rockville, 21. Signator of Juneral Service Utensee  22. Name and Address of Facility. Francis J. Collins Funeral Home Inc. 500 University Blvd, W, Silver Spri									
li,			23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.						
1	Enysician /Medical		Immediate Cause (Final disease or condition resulting in death)  a. Subdurd lie	matoma		Onset and Death			
b	Examiner		Due to (or as a consequence of):  Sequentially list conditions.	Kidney disea	SE				
	cuted nd ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	elond					
8760,	icate be executed physician and s the burial-transit	dicai Ex	resulting in death) Last  Due to (or a /a consequence of).  d.						
9	ertifica ding ph	/Med	IF FEMALE:						
O. Box	he death certifics the attending ph ched for use as t	Physician/Me		Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year			
ds, P.	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	by	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.	23e. Did tobacc	co use contribute to the cause of death?			
Record	aw requisible been 2 shouk	plete			24a. Was an	24b. Were autopsy findings available			
Vital Re		e Completed	25. Was case referred to medical	26. Place of Death	autopsy performed				
	Physici this cer al direc	ToB	examiner?  1 Yes 2 No  Hospital: 1 Impatient 2 ER/Outpatien	Osh		e 6 ☐Other (Specify)			
n of	ing Pl		27. Manner of Death 1 □ Natural 5 □ Pending (Month, Day Year) Injury 28b. Time of (Month, Day Year)	f 28c. Injury at Work?	28d. Describe how in				
Division	uttand death ctor: / y the fi	icati	Accident investigation 3/2 8/05 UN KNO 3 Suicide 6 Could not be determined determined		Propak	ole tall			
2	To the Hospital or Attanding Physician: within 24 hours after deals. To the Funeral Director: After this certific completely tilled in by the funeral director,	Il Certification;	building, etc. (Specity)	//	City or Town, Si	Kensington, MD			
	ha Hos in 24 h ha Fur pletely	edical	29a. Certifier  (Check only one)  1 ☐ Certifying Physician: To the best of my knowledge, deatt  2 ☐ Medical Examiner: On the basis of examination and/or in and manner stated.	vestigation, in my opinion, death occurre	and due to the cause ad at the time, date :	e(s) and manner as stated. and place, and due to the cause(s)			
	With Com	Σ	29b. Signature and title of certifier  Patricia Tomsko May, M.	29c. License number 15/9/6	29d.	Date signed (Month, Day, Year)			
	3		30 Name and address of person who completed cause of death (Item 23a) (Type, Patri Cla Tomsko Nay, III9 Rock V	Print) ille Pike, G-100	Rocki	ille MD 20850			
	Sta Registra	_	31. Date filed (Month Day, Year) 7 2005 32. Signature	mili	/	1			

				State of Man				-		е.
			1 - For State Registrar	Glate of Mar		rtificate of		wentar riy	Reg. No.	5   3750
	Physic	ian	Decedent's Name (First, Middle, L.	-				2. Date of D	eath	3. Time of Death
	/Medi	cal		e Butle				HPril	7 200	5 10:00 M
	Exami	ner	4a. Facility Name (If not institution, gi				or Location of Deat	th	4c. County of [	Death
	Funeral		Mallard Bay Care 5. Social Security Number 6.	Sex 7. Age (/	n yrs. last birthday)				Dorches	Birthplace (State or Foreign Country)
	Director		219-07-7154 Usual Residence of Decedent	1□M 2X)F	36 Yrs.	Months Days	s Hours Min.	Dec. 10		aryland
	Maryland f show		10a. State 10b. County	10	Oc. City, Town or Lo	ocation				10d. Inside City Limits
Q		ctor	Maryland Charle	es l	Bryans Ro	ad				1 ☐ Yes 2 📉 No
B	with the Maryland e or 28e-f show Le notified at	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of Wha	t Country?
5	ours after death with el', or Items 23e or Evande activities	Funeral	2680 Marshall Hal	.1 ROad	rin II C 12	206			USA	
9	after d		1 Never Married 2 Married	Armed Forces?  1 Yes 2X No	1		Hispanic Origin? (S ban, Mexican, Puer	to Rican, etc.)	Black, V	American Indian, Vhite, etc.
21215-0036	hours a	d by	3√ Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 □ Yes 2X No	Specify:		Specify:	31ack
15-	n 72 hours "neturel", edical Exe	Completed	15. Decedent's E (Specify only highest gi	ducation ade completed)	16a. Dece (Give	dent's Usual Occu	ipation eduring most of wo ed)	rking	16b. Kind of Busine	ess/Industry
212	filed within Hygiene. other then	omo	Elementary/Secondary (0-12)	College (1-4or 5+)		Teacher			Educa	tor
pu	be filed tal Hygi d other event, I	Be C	17. Father's Name (First, Middle, Las			ICOCHEL		ne (First, Middle	, Maiden Sumame)	ILOL
Maryland	2 should be and Menta is marked eumatic ev	P	Monroe Francis I						beth Denna	
Z Z	id 2 sho th and 27 is mu treum		19a. Informant's Name/Relationship Millie Lake (Sis						er, City or Town, State	
re,	nit. Pages 1 and 2 should be filed within 72 ho arment of Health and Mental Hygiene, ortent: If item 27 is marked other then "netur injury or other treumatic event. I'm Medical 8.		20a. Method of Disposition		20b. Place of Dispo	Address of the Control of the Contro		Date	20c. Location - City	
imo	Page ment c ant: If ury or		1X Burial 2 ☐ Cremation 3 ( `4 ☐ Donation 5 ☐ Other (Speci	Titomoval nom State	_	Cemetary		15,2005	Bucktown	, MD
Baltimore,	permit. Page Department o Importent: If any injury or once.		21. Signature of Funeral Service Lice	gsee D. A	1 22	2. Name and Addr	ess of Facility E	Boardley	Funeral H	Iome
	70 7 8 Q		23a Part 1 Enter the disease or con	polications that assessed the	lly 8	12 Hubba	rd St., C	ambrida	e, MD 2161	3
	Physician		23a. Part1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final	1 /	1		ing, such as cardiac	or respiratory a	rrest,	Approximate Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a. denyc		n				Imonth
	Examiner		Sequentially list conditions.	b. dysp	hagia	(neu	rogeni	()		Imonth
	bed Isit	nine	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events	1 . 31	onseq of ce of):					1 month
Ć,	te be executed ysician and te burial-transit	Examiner	that initiated events resulting in death) Last	c. deme					-	syears
3760,	ires that the death certificate be executed signed by the attending physician and be detached for use as the burial-transit	ical		d						
x 68	The law requires that the death certifica tte has been signed by the attending ph page 2 should be detached for use as it	Physician/Med	IF FEMALE:				-			
Вох	attenc for us	cian	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time	Fetal death 3	Ectopic pregn <i>a</i> nc Other (specify)	;y		23d. Date of Month	delivery Day Year
P.O.	t the d by the ached	hysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	or death 5	TOTHER (Specify) _				ŕ
Ś	es tha gned I be det	by P	Part II. Dther significant conditions	contributing to death but no	ot resulting in the ur	nderlying cause gr	ven in Part I.	23e. Did t	obacco use contribute	to the cause of death?
ord	w requir been si should	sted						1 🗆 '	res 252 No 3□	Probably 4 Unknown
Record	has b	Completed						24a. Was autop	osy / prior	autopsy findings available to completion of cause of
			25. Was case referred to medical					1 ☐ Yes	2 <b>Y</b> No 1 □ Y	es 2 No
ί	N 15	To Be	examiner? 1 ☐ Yes 2 ☐ 16	Hospital: 1 ☐ Inpatient	2 ☐ ER/Outpatien	t 3 DOA Ott	26. Place of Dea		<i>ine)</i> dence 6 □Other (S	nacifu)
n of	ding Ph h. After th funeral		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Ye	ar) 28b. Time of Injury	28c. Inju	ry at		now injury occurred	oedily)
Division	Attendi death. ctor: A y the fu	icati	2 Accident investigatio			M 1	Yes 2□No			
Div	after death after death Director: d in by the	Certification;	4 Homicide determined	28e. Place of Injury - building, etc. (S	At home, farm, stre pecify)	et, factory, office		28f. Location (S City or Tox	Street and Number or vn, State)	Rural Route Number,
	ospite hours unerell y filled		29a. Certifier 1 Certifying Pt	ysician: To the best of m	y knowledge, death	occurred at the til	me, date and place,	and due to the	cause(s) and manner	as stated.
	To the Hospitel or Attending within 24 hours after death.  To the Funerel Director: After completely filled in by the funer	Medical	one)	niner: On the basis of exa and manner stated.	mination and/or inv	estigation, in my o	opinion, death occur	red at the time,	date and place, and d	ue to the cause(s)
	or to no	2	29b. Signature and title of certifier			29c. Licens			29d. Date signed (Mo	
7			30. Name and address of person who	completed cause of death	(Item 23a) /T	1400	344 13		4/11/0	15
			Dathlicis Toh	nean In	O Bran	ble Si	treet C	ambri	dge, m.	05 0 21613
	Sta	te	31. Date filed (Month, Day, Year)	2005 32. Registrar's	Signature	1			( )	
	Registr	वा	140 10 A	J. J. A.S.	The State of					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible
State of Maryland / Department of Health and Mental Hygiene

For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** onan Trancis APRIL 2005 1:00 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** QUEEN ANNE'S 202 MERGANSER COURT CHESTER If Under 1 Year | If Under 24 Hrs. | 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1**X** M 2□ F Yrs. Director 029-12-2727 80 JAN. 24, 1925 Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 la markad othar than "natural", or Itama 23a or 28a-1 show other traumatic evant, the Madical Examinar must be notified at 1 Yes 2 No QUEEN ANNE'S Direct 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code USA 202 MERGANSER COURT 21619 filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 XYes 2 No 1942− If Yes, Give Year or Dates: 1946 1 Never Married 2 Married WHITE 1 ☐ Yes 2 🗓 No Specify Completed by 3 XWidowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry If Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) FIRE FIGHTER PUBLIC SERVICE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 12 should be fi h and Mental H 7 la markad otl MERRILL COHAN MARGARET (UNKNOWN) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) mit. Pages 1 and 2. partment of Health a portant: If item 27 la y injury or other trau ROBERT L. GORDON, SR./STEP-SON 9707 UNDERWOOD DR., FORT WASHINGTON, MD 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State CHESAPEAKE CREMATION CENTER, LLC. 04/07/2005 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State ' 4 □ Donation 5 □ Other (Specify) STEVENSVILLE, MD 21. Signature Funsial Service License 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MD 21619 n1. Enter the diseas, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one came on each line. ydominist aske arrayon Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) law requires that the death certificate be executed the burial-transit and Due to (or as a consequence of) physician by Physician/Medical use as IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy 1 Live birth in the past 12 months? 1 ☐ Yes 2 ☐ No ō Month Day Year 4☐Pregnant at time of death 5 Other (specify) be detached ditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 **N**0 3 Probably Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No has page certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes funeral director Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident Diractor: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 - Homicide within 24 hours Kertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 3988 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D., DAVID SMITH. 29466 PINTAIL DRIVE, SUITE 5, EASTON, MD 32. Reg State 2005

DHMH 17 Rev 1/2001

Registrar

Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

			1 - For State Registrar	State of Maryl	-	artmen rtificat					Reg. No	-/1111	5 1375
	Physici		Decedent's Name (First, Middle, Last)     ROBERTO		UZ-MALDO	ONADO				2. Date of De Month APRIL	Day	y Year 2005	3. Time of Death 10:36 P M
	/Medic		4a. Facility Name (If not institution, give s	treet and number)		4b. City,	Town, or	Location of	of Death			. County of Dea	th
1			Bowie Health Cer	nter			Bow	ie			Pı	rince G	eorge's
	Funeral		Social Security Number     6. Sex		rs. last birthday)	If Under Months	1 Year Days	If Under Hours	Min	8. Date of Bi	rth	9 Bir	thplace (State or Foreign ountry)
	Director		300-40-3319	M 2□F 7	3 Yrs.		54,5	110010		Nov. 2	1,193	31 Pue:	rtő Rico
	D		Usual Residence of Decedent  10a. State 10b. County	100	City, Town or Lo	cation							10d. Inside City Limits
	show	<u>_</u>			•								1 ☑ Yes 2 ☐ No
	or 28a-1	ecto	MD   Anne Arui	ndel	Cro	fton	0.1				10- 0'	V	41
	Mor Dean	급	10e. Street and Number			10f. Zip		1 /			rog. Cit	tizen of What C	ountry r
	s 23a	erai	1790 Sharwood Pla	ICE 12. Was Decedent Ever i	0115 13	Was Doop	211		cin? (Sne	city Vac or N		USA 14. Race - Amo	arican Indian
	lien d	by Funeral Director	1 □ Nøver Married 2 □ Married	Armed Forces? 1 X Yes 2 □ No	10.0.	If Yes, spec	cify Cuba			city Yes or No Rican, etc.)		Black, Whi	te, etc.
336	irs af	by	3 ☐ Widowed 4 ☑ Divorced	If Yes, Give Year or Dates: 196	0-64	1 🕅 Yes	2□ No	Specify:	Puer	to Rica	an	Specify: Wh:	ite
ð	72 hours after death with the Maryland "naturel", or Items 23a or 28a-1 show idical Examiner must be notified at	ted	15. Decedent's Edu	cation	16a Dece	dent's Usua	al Occupa	ation				ind of Business	
215	within 7 ene. than "n	pie	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life.	kind of wo DO NOT u	nk done d se retired	uring mos )	t or workii	ng			
21215-0036	filed withi Hygiene. other than	Completed	12		P	ostal	Wor	ker			U.S	. Posta	l Service
	be filed ital Hygid od other event, t	Be (	17. Father's Name (First, Middle, Last)							(First, Middle		Sumame)	
<u> a</u>	should be and Mental marked of umatic eve	인	Domingo Cruz					Carm	en M	aldona	do		
Maryland	2 should be filed within and Mental Hygiene. is marked other than sumatic event, the M		19a. Informant's Name/Relationship (Ty			-						or Town, State,	
	and ealth m 27		Vilma Cruz-Monten									, MD. 2	
ore	Pages 1 and 2 should be filed within 72 hours after death with the Maryla hent of Heatth and Mental Hyglene. Int: if item 27 is marked other than "naturel", or items 23a or 28a-1 shown: if item 27 is marked other than "naturel", or items 23a or 28a-1 shown: if yor other traumatic event, it is Madical Examiner must be notified at		20a. Method of Disposition 1   ☐ Burial 2 ☐ Cremation 3 ☐ R		<ul> <li>b. Place of Dispo cemetery, crea</li> </ul>					ate		ocation - City or	
Ë	Pag Iment Iant:		' 4 □ Donation 5 □ Other (Specify)	MI	). Veter							wnsvill	e, MD.
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 ti eny injury or other tra once.		21. Signature of Funeral Service Licelys	5 00		2. Name ar				all Fu			1 5
	20 5 • a		(Buan)	touck		512 N				Bowie		D. 207	
			23a. Part1. Enter the disease, or complishock, or heart failure. List only or	ne cause on each line.	eath. Do not en	er the mod	ie oi uyiri	J. Sucii as	Cardiac	r respiratory a	irrest,		Approximate Interval Between Onset and Death
5	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	CARDIO-PUL		ARRES	Г						
	Examiner			Due to (or as a con									
- 4		-	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, Disease or injury	Due to (or as a con									
	uted J ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events										
ć	exec in an	Exa	resulting in death) Last	Due to (or as a con	sequence of):	-							
68760,	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	icai		l									
68	tifica ng ph as th	led											
Вох	death certifica attending pl	an/N	23b. was decedent pregnant	3c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ I		∃Ectopic p	rennancy					23d. Date of de	
	deal	sicis	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at time 9☐Unknown		Other (sp						Month	Day Year
P.O.	at the i by ti	Physician/Med	9 Unknown										
	res that the de signed by the a be detached f	by	Part II. Other significant conditions cor PROSTATE CANCER	tributing to death but not	resulting in the u	nderlying o	ause give	n in Part I.	•				o the cause of death?
Records,	w requir been si should I	Completed	TRODINIE GRADER				· <u>-</u>				105 2	□No 3□P	
ec	law las b	npie								24a. Was	psy	24b. Were a prior to	utopsy findings available completion of cause of
= =	The sate has page	Con								1 Yes	ormed? 2 <b>X</b> No	death?	
Vital	Physician: r this certific ral director.	Be	25. Was case referred to medical examiner?				-			(Check only			Health
of	hysi this c	2	1 195 2 NO		2 ER/Outpatie								cify) Center
no	ling P	ion	27. Manner of Death  X Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Yea	r) 28b. Time o		28c. Injury Work			28d. Describe	how inju	ry occurred	
Sic	Attending r death. ector: After by the fune	icat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury -	At home farm st	M (actor		res 2□		Rf Location	Stroot ar	nd Number of P	ural Route Number,
Division	or A after Direction by	ertif	4 Homicide determined	building, etc. (Sp	ecify)	oot, ractor	y, onice		1 *	City or To	wn, State	9)	urar noute i variber,
	Hospital La hours Funeral tely filled	S E	29a. Certifier 1 Certifying Phys	sician: To the best of my	knowledge, deat	h occurred	at the tim	e date an	nd place, a	and due to the	cause(s	) and manner a	s stated
	24 h 24 h e Fur	Medical Certification:	(Check only 2 Medical Examinate)	ner: On the basis of exam and manner stated.	nination and/or in	vestigation	, in my or	oinion, dea	th occurre	ed at the time.	date and	d place, and du	o to the cause(s)
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Me	29b. Signature and fille of certifier	1/1		290	c. License				29d. Da	te signed (Mon	th, Day, Year)
			1 Mulle	1/1/		age and a second	MD3	4028			APRI	L 8, 20	05
0	13/111		30. Name and address of person who co										
1-	UVO		MICHAEL P. VILLAR	T	50 IRVI	NG ST	REET	NW,	WASH	INGTON	,DC	20422/6	88
	Sta Regist		31. Date filed (Month, Day, Year)  APR 1 1 2005	7. Registrar's S	ignature &	A. 1							

DHMH 17 Rev 1/2001

		1 - For State Registrar  1. Decedent's Name (First, Middle, Las		laryland /	Certific					eg. No. 2 (	05	3. Time of Death
Physici /Medic Examir	al	Edna 4a. Facility Name (If not institution, give	Mae Crum				r Location of	A		2, Day 200.	y of Death	3:40 AM
Funeral Director		Beverly Health  5. Social Security Number 579-10-4836 6. Security Number		er ge <i>(In yrs. l</i> ast b 87		reder der 1 Year ns Days	If Under 2 Hours	4 Hrs. 8. Min. Ju	Date of Birth (Month, Bay		deric  9. Birth	K blace (State or Fore ntry) ginia
a-f show	tor	Usual Residence of Decedent  10a. State 10b. County  Maryland Montgom	ery		wn or Location rer Spri	ng						10d. Inside City Lim
23a or 28.	Funeral Director	10e. Street and Number 404 Lanark Way			10f.	Zip Code 2090	1		1	U.S.	Whal Cour	ntry?
ila Tygiene. sd other than "natural", or lieme 23a or 28a-1 show event, the Madical Examinational Langilliad at	by Funer	11. Marital Status  1 Never Married 2 Married  3 XWidowed 4 Divorced	12. Was Deceden Armed Forces 1 ☐ Yes ② If Yes, Give Year or Dates:	?	1	cedent of H pecify Cuba	ispanic Orig an, Mexican, Specify:	in? (Specif Puerto Ric	y Yes or No- an, etc.)		ce - Americ ick, White, fy: Wh	
Hygiene. other than "natu ant, the Medical	Completed by	15. Decedeni's Ed (Specify only highest grad Elementary/Secondary (0-12)	ucation de <i>completed)</i> College (1-4or		a. Decedent's U (Give kind of life. DO NO Secret	<i>work d</i> one d Tuse retired	during most ( d)			16b. Kind <i>o</i> f E	Business/In cienc	
nd Menial Hy marked oth matic event	To Be (	17. Father's Name (First, Middle, Last)	Fox					1	Minnie	Maiden Suma G. Cl	ark	
if Health and Meritem 27 is market other traumatic		19a. Informant's Name/Relationship (7 Mrs. Mabel L. Rye		8	b. Mailing Addr 3604 Gue	Road	and Number I, Dama	or Rural R ascus	oute Number, Mary	land 20	, State, Zip 08 <b>7</b> 2	Code)
Department of He Important: If Iten any injury or oth		20a. Method of Disposition  1 X Burial 2 ☐ Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Specify)	)	20b. Place cemete	of Disposition (in any crematory of Olivet C	er other place emetery		1 <b>1</b> 5,	2005		rick,	own, State Marylar
Impor any in	de d	21. Signature of Funeral Service Licent	<b>1</b>	100255	Keene 106 E	and Addres y and ast C	Basfo Basfo hurch	ord PA	Fune Frede	ral Hor rick, N	ne 1D 21	701
Medical aminer transit the purial-transit	icai Examiner	disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as	EBRAC s a consequence TEW s a consequence s a consequence	of): المار . of):	7 77 10	~ T(0)					
by the attending ph) tached for use as th	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal deat	h 3 Ectopio						ate of delive	ory Day Year
gned be de	by	Part II. Other significant conditions co	ntributing to death	but not resulting	in the underlyin	g cause give	en in Part I.			pacco use con es 2 □ No		ne cause of death
도를	ompieted								24a. Was a autops perform	y ned/?	death?	psy findings avail inpletion of cause 2/2 No
icate has been si r, page 2 should b	0						,		heck only on	e) ence 6 □Oth	ner (Specifi	1)
n. After this certificate has funeral director, page 2	To Be C	25. Was case referred to medical examiner?  1  Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	Hospital: 1  Inpati 28a. Date of Inj (Month, Da	ury 28b.	Time of Injury M	DOA Other	4 La urs	28d		w injury occur	red	
n. After this certificate has funeral director, page 2	BeC	examiner? 1  Yes 2 No  27. Manner of Death 1 Natural 5 Pending	28a. Date of Inj (Month, Da	ury 28b.	Time of Injury M	28c. Injury Work	at k?	28d	. Describe ho	reet and Numl		l Route Number,
n. After this certificate has funeral director, page 2	edical Certification: To Be C	examiner?  1 Yes 2 No  27. Manper of Death  1 Natural 5 Pending investigation  3 Suicide 6 Could not be determined  29a. Certifier (Check only one)  1 Certifying Phyone	28a. Date of Inj (Month, Da 28e. Place of In building, e	jury - At home, fic. (Specify)  of my knowledge of examination ai	Time of Injury M  arm, street, facting, death occurrend/or investigat	28c. Injury Work 1 [] ory, office ed at the timon, in my op	y at (? Yes 2 No	28d o 28f.	Location (St City or Town due to the ca at the time, do	reet and Numb n, State) ause(s) and ma ate and place,	per or Rura anner as st and due to	ated. the cause(s)
fler this certificate has ineral director, page 2	Certification: To Be C	examiner?  1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined  29a. Certifier Check only 2 Medical Exam	28a. Date of Inj (Month, Da 28e. Place of In building, e	jury - At home, fic. (Specify)  of my knowledge of examination analysis	Time of Injury M  arm, street, facting, death occurrend/or investigat	28c. Injury Work 1 \( \text{\tin{\text{\tex{\tex	y at (?) Yes 2 No	28d 28f. place, and	Location (St City or Town due to the ca at the time, da	reet and Numb, State)  ause(s) and mate and place, 9d. Date signe  April	anner as stand due to	ated. the cause(s)  Day, Year)

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. Nd.) 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** 5, a M April 2005 1:36 Maria P. Cogliandolo /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Holy Cross Hospital Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Min 1 ☐ M 2 🕱 F Yrs. 577-58-1708 **Director** 71 26, Italy Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Maryland Prince George's Adelphi Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10925 Bond Road 20783 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: 1 Never Married 25 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic event gode. Be ( Francesco Saglimbeni Stefana Zizzo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pantaleo Cogliandolo/ Husband 10925 Bond Road, Adelphi, Maryland 20783 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State April 8, Gate of Heaven Cemetery 1 4 ☐ Donation 5 🖾 Other (Specify) 2005 Silver Spring, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc. noher 500 University blvd, W, Silver Spring, MD 20901 emplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, and one cause on each line. 23a. Part1. Enter the disease, or shock, or heart failure. List Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** Sepsis 48 Hours resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): The law requires that the death certificate be executed use as the burial-tran that initiated events resulting in death) Last and Due to (or as a consequence of): signed by the attending physician Division of Vital Records, P.O. Box 68760 Physician/Medical d IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Į0 in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? certificate has page 2 autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 🖾 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 1 ☐ Yes 2 🛣 No 0 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: after death. Director: After 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation м 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral C 2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D56153 April 6, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kristie D. Nowak, M.D. 1500 Forest Glen Road, Silver Spring, Md 20910 31. Date filed (Month, Day, Year), APR 07 State Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** April 2005 1:00P Fallen Childress /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 15306 Barningham Court Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1X M 2 ☐ F Yrs 577-46-4602 1933 Washington, D.C Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State or 28a-f show Examiner must be notified at 1 ☐ Yes 2X No Directo Maryland Montgomery Silver\_Spring 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 15306 Barningham Court 20906 USA items 23a Funeral death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or ite ury or other traumatic event, the Medical Exerts as ☐ Yes 2 ☐XNo Yes, Give 1 Never Married 2 X Married Specify: White Baltimore, Maryland 21215-0036 1 Yes 2 No by 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Intelligence Agent Dept. of Defense 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Elmer Thomas Childress Louise Wall 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Virginia C. Childress/wife 15306 Barningham Court Silver Spring, MD 20906 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Aprile 9, 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or 2005 W. Arundel Crematory Odenton, Maryland \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Ligensee Going Home Cremation Service P.O. Box 784 Dever MO1251 Beverly L. Heckrotte, P.A. Clarksville. MD 21029 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition **Physician** a Exacerbation of Chronic Obstructive Pulmonary Disease months resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) attending physician for use as the burial Box 68760, Completed by Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) P.0. detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, page 2 should be 1₩ Yes 2□No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performes 2□ No 1 Yes 2 No 1 Tyes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) director Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 2 ER/Outpatient 3 DOA Certification: To this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death.

Funerel Director: A 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier within 24 ho To the Fune completely f (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and We of certifier 1) 5006/2 April 7, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BrookevilleRoof Brookeville Mary Kond 20833 MALLER SAMUEL G. m.A 4901 31. Date filed (Month, Day 32. Pagistrar's Signature State 1 2005 Registrar

		1 - State Registrar	amend ite	State of Mary  35 PER FH	•			Re	g. No.	5	13756
Р	Physician		ime (First, Middle, La:	St)				2. Date of Death Month	Day	Year	3. Time of Death
	/Medical	A T1	rginia Pu			45 Oits Town	al and a d Dank	April	11 2 4c. County of	2005	5:30 p <sup>M</sup>
E	Examiner		Howard Market Market (If not institution, give	e street and number) entist Hospi	tal		or Location of Death			ntgom	erv
E,	uneral	5220 01 vit			yrs. last birthday	) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day,			ace (State or Foreign
	rector	<del>220 21</del>	<del>-9387</del> ¹	□M 2XF 8	Yrs.	Months Days	Hours Min.	Oct. 7,	1923	Mar	yland
l g	3 3	Usual Residence	of Decedent	10	c. City, Town or L	ocation				10	d. Inside City Limits
Maryland	fed al		Dorch		,,		oridge				1 □ Yes 2 XNo
Baltimore, Maryland 21215-0036 FCLC permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.	be notified	10e. Street and				10f. Zip Code		10	g. Citizen of W	hat Count	ry?
22 =	123a distribute	3558	Height Ro				21613		USA		
1 8	r Itams 23s	11. Marital Status	s arried 2 Married	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☑ No	in U.S. 13.	. Was Decedent of I If Yes, specify Cub	lispanic Origin? (Spe an, Mexican, Puerto	Rican, etc.)		- America , White, e	
036 urs aft	al', or Exami	3 Widowed	d 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 No	Specify:		Specify:	wh	ite
5-0(	natura ileal I	(Sr	15. Decedent's Ed	ducation	16a. Dece	edent's Usual Occup e kind of work done	pation during most of worki	na 1	6b. Kind of Bus	sine <i>s</i> s/Ind	ustry
Within Pe	t, the Madical It.	Elementary/Se	econdary (0-12)	College (1-4or 5+)	life.	homemal			OWN	home	
d 2 Filled v Hygie	ther t		ne (First, Middle, Last)	)		Tionication	18. Mother's Name	(First, Middle, M			
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Baltimore, permit. Pages 1 ar Department of Hea	or otl	20a. Method of D	2 Cremation 3	JHemovai from State		esition (Name of ematory or other pla	1 .		Oc. Location - (	-	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death APRIL Day **Physician** EMORY B. DEEL 2215 10 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Wicomico REGIONAL 5a/isbilis teninsula Medicul CANFOR If Under 1 Year If Under 24 H 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Social Security Number 8. Date of Birth (Month, Day, Year) Hours Min. 1**X**] M 2□ F Months Days 234-38-5430 76 Director 01-21-1929 VIRGINIA Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir Items 23a or 28a-f show ther must be notified at N Yes 2 No Director MD WICOMICO SALISBURY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 315 PARK HEIGHTS AVENUE 21804 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1X Yes 2 □ No ARMY If Yes, Give Year or Dates:1945-65 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after inent of Health and Mental Hygiene. Int: If itam 27 Is marked othar than "natural", or Iter 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 27 No Specify: Completed by WHITE 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) ROUTE SALESMAN 12 BAKERY f Health and Mental Hygitam 27 is marked othar other traumatic evant, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be NOAH DEEL ဥ DELIS POWERS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 315 PARK HEIGHTS AVENUE, SALISBURY, MARYLAND 21804 EVELYN DEEL - SPOUSE Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages ' Department of F Important: If its any injury or ot once. 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State SPRINGHILL MEM.GDNS. 04-14-2005 \* 4 ☐ Donation 5 ☐ Other (Specify) HEBRON, MARYLAND 22. Name and Address of Facility BOUNDS FUNERAL HOME, INC. 21. Signature of Euneral Service Licensee el1330 705 EAST MAIN STREET, SALISBURY, MARYLAND 21804 23a. P. rt1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Sezzia Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** rother ivol Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examine sician and burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 as the esn s IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an 2 2 No 1 Yes Division of Vital the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Dipatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Certification: To 2 ER/Outpatient 3 DOA his 28c. Injury at Work? 27. Manney of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending 1 TYes after death. death. investigation 2 Accident 6 Could not be determined 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 4 Homicide hin 24 hours aff the Funeral Di mpletely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Chack only one) within 2. To the I 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 5100M 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

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32. Degistrar's Signature

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middla, Last) 2. Data of Daath 3. Time of Death Month Day April 6, 2005 **Physician** liemae 4:30 P.M. /Medical 4a Fecility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Daath Examiner Futurecare Pineview Nursing Home Clinton If Undar 24 Hrs. Prince George's If Under 1 Yaar 8. Data of Birth (Month, Day, Yaa 11/16/18 7. Aga (In yrs. last birthday) 5. Social Sacurity Number Birthplaca (State or Foraign Country) Funeral Min Months Days Hours 1□ M 2□ F Yrs. 86 No. Carolina Director 241-26-2282 Usual Rasidence of Decedant 10b. County 10a. Stata 10c. City, Town or Location 10d. Insida City Limits D.C. Yos 2 □ No Washington Funeral Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Coda 1336 G Street, N.E. 20002 U.S.A. 12. Was Decedent Evar in U,S. Armed Forcas? 13. Was Decedent of Hispanic Origin? (Specify Yas or No If Yas, specify Cuban, Maxican, Puarto Rican, etc.) Race - American Indian, Black, Whita, atc. 11. Marital Status 1 ☐ Yas 21∑ No If Yas, Give Yaar or Dates: 1 Nevar Married 2 Married 1 ☐ Yes 21 No Black Specify: Be Completed by 3 ☑ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during lifa. DO NOT use retired) 15. Decedent's Education (Specify only highast greda complated) 16b. Kind of Businass/Industry ring most of working Elemantary/Secondary (0-12) Collega (1-4or 5+) 12th t. Pages 1 and 2 should be filed w rtment of Haaith and Mantal Hygien rtant: If Item 27 is marked other ti njury or other traumatic event, the Beautician Cosmetics 17. Fathar's Name (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maidan Sumama) Will Dixon Carrie Mackey 19b. Mailing Addrass (Straat and Number or Rural Route Number, City or Town, Stata, Zip Coda) 19a. Informant's Name/Ralationship (Type, Print) Caroleen Turner/Niece 7012 Tarquin Ave., Temple Hills, md. 20748 20b. Place of Disposition (Name of cematery, cremetory or othar placa) 20a. Mathod of Disposition 20c. Location - City or Town, Stata Burial 2 Cramation 3 Ramoval from Stata Maryland Nat'l. Mem. Park 4/12/05 Laurel, Md. 4 ☐ Donation 5 ☐ Othar (Specify) 22, Nama and Addrass of Facility H.S. Washington & Sons Co., Inc. 4925 Burroughs Ave., N.E., Washington, D.C. 20019 21. Signature of Funeral Service Licenses any Dute W. 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onsat and Death **Physician** 4SAM CALDIOVASC immediata Cause (Final disaasa or condition resulting in death) /Medical Examiner Examine Sequentially list conditions, if any, laading to immadiata causa. Entar Undartying Causa (Diseasa or injury that initiated avants rasulting in daath) Last Dua to (or es a consequence of): Physician/Medical Dua to (or as a consaquanca of): Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yas 2 No 3 Probably 4 Unknown ģ I Director: After this certificate has been signed in by the funeral director, page 2 should be 24b. Were autopsy findings available prior to 24a. Was an autopsy performad? Be Completed completion of cause of death? 2 ANS 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Othar: 4 A vursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No Medical Certification: To 2 ER/Outpatient 3 DOA 28a. Data of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 27. Manner of Death 28d. Describe how injury occurred 1 ZNatural Injury 5 Panding 1 ☐ Yes 2 ☐ No invastigation 2 Accidant 6 Could not be determined 3 Suicida 28e. Place of Injury - At homa, farm, straet, factory, office building, etc. (Specify) Location (Straat and Numbar or Rural Routa Numbar, City or Town, Stata) 4 - Homicide 29a. Certifier 1/ certifying Physician: To the best of my knowladge, death occurred et tha tima, data and place, and due to the cause(s) end manner as steted

completaly fillad in by To the Hospital within 24 hours a To the Funeral D

death.

aftar

Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760.

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0020

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State Registrar

W.D 31. Data filad (Month, Day, Year) APR 1 1 2005

(Check only

29b. Signature and title of certifier

2070 OUD LINE CED 32. Registrar's Signature

addrass of person who complated cause of deeth (Item 23a) (Type, Print)

2 Medical Examiner: On the basis of exemination end/or investigation, in my opinion, death occurred at tha time, date and place, and due to the cause(s) and mannar stated. 29c. License numbar

29d. Data signad (Month, Day, Yaar)

Celestino Delcid Delcid
05-02414
crn
1- State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

<del>۷4</del>	14		1 - For State Registrar	State of Ma	arylan		artmen			ınd Me		giene Reg. No.	2000	10-	750
	0.	es.	Decedent's Name (First, Middle, Last)							2	2. Date of Dea	ath		3. Time of D	eath
	Physici /Medio		Celestino Del	Cid Del	Cid						Month April	Day 06	2005	5:46 A	м д
	Examin		4a. Facility Name (If not institution, give s	treet and number)			4b. City,	Town, or	Location of	f Death		4c.	County of Death		
			1204 Downes Road						: Spri				Montgome	ery	
	Funeral		5. Social Security Number 6. Sex	7. Ag		last birthday)	If Under Months	1 Year Days	If Under 2 Hours	Min.	Date of Birt (Month, Da	th y, Year)	Cou	place (State or i	-
	Director		Usual Residence of Decedent		86	Yrs.				0	4-06-1	919	E1 :	Sálvado	r
	land ow		10a. State 10b. County		10c. Cit	y, Town or Lo	ocation							10d. Inside City	Limits
	Mary -f sh fied	ţ	Maryland Montgomer	у		Silver	r Spri	ing						1X Yes 2	2 □ No
	r 28a	Director	10e. Street and Number				10f. Zip	Code				10g. Citi:	zen of What Cou	ntry?	
	th with	a D	1204 Downs Drive					209	904			Е	1 Salvad	for	
	ams ams	iner	11. Marital Status 1	12. Was Decedent Armed Forces?		S. 13.	Was Deced			in? (Speci	fy Yes or No- can, etc.)		14. Race - Ameri Black, White,	can Indian,	
36	within 72 hours after death with the Maryland ene. than 'natural', or itams 23a or 28a-f show the Madical Examiter must be notified at	by Funeral	1 Never Married 2 Married	1 ☐ Yes 2 🔯 f			1X Yes 2						Specify: White		
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7	n 72 n "naf	Completed	15. Decedent's Educ (Specify only highest grade	completed)		(Give	dent's Usua kind of wor DO NOT us	k done d	lutina most i	of working		16b. Kir	nd of Business/In	idustry	
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D	I Hygie othar	Be C	17. Father's Name (First, Middle, Last)						18. Mother	's Name (	First, Middle,			/еп	
au	Mental I Merkad o arkad o atic eva	To B	Clemente Del Cid						Valen	tina	Del (	Cid			
Maryland 21215-0036	2 should and Men le marka aumatic		19a. Informant's Name/Relationship (Typ	oe, Print)		19b Maili	ng Address						Town, State, Zij	Code)	
≥ `	and 2 salth n 27 l		Jose H. Miranda/So	on		Silv	er Spi	ring	, Mary	y land	, 2090	)4			
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or itams 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at QRCS.		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Re	emoval from State	20b. P	lace of Dispo emetery, crea	osition (Name	ne of ther place	9)	Dat	е	20c. Lo	cation - City or To	own, State	
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391	Depart Depart Import any in		21. Signature of Funeral Service License	P R									eral Hom		
	<u> </u>		v wanda c	- Exa	ON								C. 20010		
			23a. Part 1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final	e cause on each lir	i the deatr									Approximate Interval Betwe Onset and De	en eath
	Pnysician /Medical		disease or condition resulting in death)	Hyperten	BLUE		word	iero	nc ca	valio	vascul	or d	usedse		
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9	ing p	Mec	IF FEMALE:			_									
Вох	eath certific attending p	lan/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome 1 Live birth	2 Fetal	death 3	Ectopic pre					2	3d. Date of delive Month	ery Day Yea	ar
o.	at the de by the a stached f	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□Unknown	time of de	eath 5	Other (spe	ecity)					77.0.117	July 100	
<u>a</u>	The law requires that the death certifite has been signed by the attending tage 2 should be detached for use as	Ph.	Part II. Other significant conditions cont	tributing to death be	ut not resu	ulting in the u	nderlving ca	use aive	n in Part I.		23e. Did to	bacco us	se contribute to the	ne cause of dea	ith?
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Vital		മ	25. Was case referred to medical						OS Place	of Dooth //	1 Nes	2□No	1 Yes	2 No	
	ysician: is certific director,	0 B	examiner?	ospital: 1 🔲 Inpatie	nt 2 🗆 i	ER/Outpatier	nt 3 □ DO/	A Othe					₩Other (Specif	w at sc	one
0	ding Ph h. After thi tuneral	T:U	27. Momer of Death	28a. Date of Injui	ry	28b. Time of		Bc. Injury Work			d. Describe h			n at sc	CHC
io	Attending I death. ctor: After y the funer	atio	1	(111011111)	, , , , ,	пцогу	М		es 2 □ No	О					
Division of	il or Attenation after deatl	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injubulding, etc	ury - At ho	me, farm, str	eet, factory,	office		28f	Location (S City or Tow	treet and n, State)	Number or Rura	I Route Number	r,
	ital o														
	Hosp 24 hos Funa (tely fi	edical	29a. Certifier 1☐ Certifying Physi (Check only 2X Medical Exemin	er: On the basis of	examinat	wledge, deatl ion and/or in	n occurred a vestigation,	at the time in my opi	e, date and inion, death	place, and occurred	d due to the c at the time, c	ause(s) a date and i	and manner as si place, and due to	ated. the cause(s)	
	To the Hospital or Attending Physician: within 24 hours atter death 'To the Funaral Director: After this certific completely filled in by the funeral director,	Med	one) 29b. Signature and title of certifier	and manner sta	ateg.			License					signed (Month,		
)	\$ 50		1a. D. NM	10. Ov	\ I h										
			30. Name and address of person who con	noleted cause of de	eath (Item	23a) (Tyne	Print)	OCM	Ľ.			Apri	1 07, 2	UU )	
(	6)		Tasha Z Green	1	Min			1 Pe	nn Sta	reet.	Baltim	ore	Maryla	nd 2120	1
•	Sta	te	31. Date filed (Month, Day, Year)	32. Degistra	ar's Signat	ture							y±a.	2120	-
· ·	Registr	ar	APR 1 1 2005	en de	400	Me									

Physician  Medical Examiner  1900 Rosemont Avenue  Fuederick  Fuederick  Fuederick  Frederick  100. 296 96 97s. Months Days Hours War Under 24 Hr. 8. Date of Bird. Mary 8, 100 8 9. Serptes of Service Mary 8, 100 8 9. Serptes of Service Mary 8, 100 8 9. Service Mary 8,				1 - For State Registrar					Mental Hygi	ene g. No 2 0 0	5_13760
## Committee   Specific Name of not restations able and marked   1900 ROSEGOOT A VENUE   1900 ROSEGOOT		Physic	ian		et)		D:11				3. Time of Death
Trederick   Frederick   Frederick   Frederick   Social Search Processor   Social Search Proces										, 2005	1:00 am
Second Black   Property   Comment	4	Exami	ner						ath		
Director   Part   Director   Part   Director   Part   Director   Part   Director   Part   Director   Directo						the see to a title to			- 1		
100. Special part   100. County   100. County   100. County   100. Execution   100. Execu		Director		218-56-9160					B. Date of Birth (Month, Day, May 8,	908	Birthplace (State or Foreign Country) COTSIA
Alonzo  Bull  Susan  Pearl  Poull  Bull  Susan  Pearl  Poull  Bull  Susan  Pearl  Poull  Bull  Susan  Pearl  Susan  Pearl  19th Mailing Address (Sirver and Knimber or Rusal Fours Number or Rusal Fou		/land				•					10d. Inside City Limits
Alonzo  Bull  Susan  Pearl  Poul III  Bull  Susan  Pearl  Poul III  C. Hall Dillon, Jr/Son  19th Mailing Advises (Sineer and Ammeeror Pausi Fourish Mumbers: Cyr y Trem. State Zyr Code  C. Hall Dillon, Jr/Son  19th Mailing Advises (Sineer and Ammeeror Pausi Fourish Mumbers: Cyr y Trem. State Zyr Code  C. Hall Dillon, Jr/Son  19th Mailing Advises (Sineer and Ammeeror Pausi Fourish Mumbers: Cyr y Trem. State Zyr Code  C. Hall Dillon, Jr/Son  19th Mailing Advises (Sineer and Ammeeror Pausi Fourish Mumbers: Cyr y Trem. State Zyr Code  C. Hall Dillon, Jr/Son  19th Mailing Advises (Sineer and Ammeeror Pausi Fourish Mumbers: Cyr Y Trem. State Zyr Code  C. Hall Dillon, Jr/Son  19th Mailing Advises (Sineer and Ammeeror Pausi Fourish Mumbers: Cyr Y Trem. State Zyr Code  C. Hall Dillon, Jr/Son  19th Mailing Advises (Sineer and Ammeeror Pausi Fourish Mumbers: Cyr Y Trem. State Zyr Code  C. Hall Dillon, Jr/Son  19th Mailing Advises (Sineer and Ammeeror Pausi Fourish Mumbers: Cyr Y Trem. State Zyr Code  C. Hall Dillon, Jr/Son  19th Mailing Advises (Sineer and Ammeeror Pausi Fourish Mumbers: Cyr Y Trem. State Zyr Code  Commellery Correlation Pausin State  19th Mailing Advises (Sineer and Ammeeror Pausi Fourish Mumbers: Cyr Y Trem. State Zyr Code  Commellery Correlation Pausin State  19th Mailing Advises (Sineer And Ammeeror Pausi Fourish Mumbers: Cyr Y Trem. State Zyr Code  20th Mailing Advises (Sineer and Ammeeror Pausi Fourish Mumbers: Cyr Y Trem. State Zyr Code  20th Mailing Advises (Sineer And Ammeeror Pausi Fourish Mumbers: Cyr Y Trem. State Zyr Code  20th Mailing Advises (Sineer And Ammeeror Pausi Fourish Mumbers: Cyr Y Trem. State Zyr Code  20th Mailing Advises (Sineer And Ammeeror Pausi Fourish Mumbers: Cyr Y Trem. State Zyr Code  20th Mailing Advises (Sineer And Ammeeror Pausi Fourish Mumbers: Cyr Y Trem. State Zyr Code  20th Mailing Advises (Sineer And Ammeeror Pausi Fourish Mumbers: Cyr Y Trem. State Zyr Code  20th Mailing Advises (Sineer And Ammeeror Pausi Fourish Mumbers: Cyr Y Trem. State Zyr Code  20th Mailing A		Mar.	to	Maryland Freder	ick	$\operatorname{Fr}\epsilon$	ederick				1⊠Yes 2□No
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Alonzo  Bull  Susan  Pearl  Poull  Bull  Susan  Pearl  Poull  Bull  Susan  Pearl  Poull  Bull  Susan  Pearl  Susan  Pearl  19th Mailing Address (Sirver and Knimber or Rusal Fours Number or Rusal Fou	5-(	72 h	etec			16a. Dec	edent's Usuat Occu	upation e during most of we	orking 16	6b. Kind of Busine	ss/Industry
Alonzo  Bull  Susan  Pearl  Poull  Bull  Susan  Pearl  Poull  Bull  Susan  Pearl  Poull  Bull  Susan  Pearl  Susan  Pearl  19th Mailing Address (Sirver and Knimber or Rusal Fours Number or Rusal Fou	21	ithin in ith	npl			+) Tos	DD NDT use retir	ed)	, many	Dublic	Sahaal
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MOO7O6   106   East Church St. Frederick, Mary   and 21   East   Mary   and 22   East   East   Mary   and 23   East   East   Mary   and 24   East   Mary   and 25   East   East   Mary   and 27   East   Mary   And 27   East   Mary   And 28   East   Mary   And 28   East   Mary   And 28   East   Mary   And 28   East   Mary   And 28   East   Mary   And 28   East   Mar	, Mar	and 2 sho ealth and n 27 is m				19b. Mai 1930	ling Address <i>(Stree</i> )1 Poinse	et and Number or R tta Court	Gaither, Gaither	city or Town, State sburg, M	9, Zip Code) D 20879
MOO7O6   106   East Church St. Frederick, Mary   and 21   East   Mary   and 22   East   East   Mary   and 23   East   East   Mary   and 24   East   Mary   and 25   East   East   Mary   and 27   East   Mary   And 27   East   Mary   And 28   East   Mary   And 28   East   Mary   And 28   East   Mary   And 28   East   Mary   And 28   East   Mary   And 28   East   Mar	imore	Pages 1 nent of H ant: if iter ury or oth		1 XBurial 2 ☐ Cremation 3 ☐		Rome Cer	ematory or other pla netery	Apr 20,	2005 Pr	coctorvil	le, Ohio
Shock, or heaf failure. List only one cause on each line.    Physician   Micedical Examiner	Balt	Deput Import any nj		21. Signature of Funeral Service Licens	Jeu-	M00706	22. Name and Addr Keeney & 106 Fast	Basford	P.A. Fune	eral Home	land 21701
Due to (or as a consequence of):    Section   Part		/Medical		Immediate Cause (Final disease or condition resulting in death)	a. Cerebral  Due to (or as a	Vascular consequence of):	Accident	ing, such as cardia	ic or respiratory arres	ι,	Interval Between Onset and Death
The first minimal death) Last    Composition of the composition of the		led sit	nlner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence of):					WCCRS
Second   S		xecu and al-trar	xan	that initiated events							Years
February   February	9	be e siciar burit									V
The state of the significant contributing to death but not resulting in the underlying cause given in Part I.    1   Yes 2   No 3   Probably 4   1   1   Yes 2   No 3   No	387	icate phys s the	gg	•	d. Hypothyl	OLULSII					rears
The state of the significant contributing to death but not resulting in the underlying cause given in Part I.    1   Yes 2   No 3   Probably 4   1   1   Yes 2   No 3   No		0 0 0	ysiclan/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No	1□Live birth 2 4□Pregnant at t	Fetal death 3		cy			
The part of the pa	٩	that hed b deta		Part II. Other significant conditions co	ntributing to death but	t not resulting in the	underlying cause gr	ven in Part I.	23e. Did tobac	cco use contribute	to the cause of death?
The part of the pa	rds	quire; n sign							1 ☐ Yes	2 □ No 3 📉	Probably 4 Dunknown
A comparison of the company of the	Ö	> 0 10	lete						242 Whe an	24h Wore	autonou findinos autololo
The second of th	al Re	Ine fa ate has page 2	O						autopsy performe	d? prior to	completion of cause of
The property of the property o	5	centi	00	examiner?	Hospital:		Ot				
The state of the s		After After funer		27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of trijury	28b. Time o	of 28c. Inju	ry at rk?			pecify)
29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier  29b. Signature and title of certifier  29c. License number  29c. License number  29d. Date signed (Month, Day, Year)	É	4 5 0 G	ertifica	3 Suicide 6 Could not be	28e. Place of Injur building, etc.	y - At home, farm, st (Specify)		,100 2 110	28f. Location (Stree City or Town, S	et and Number or I State)	Rural Route Number,
April 18, 2005	:	n 24 hours n 24 hours ne Funera		Check only 2 Medical Exami	ner: On the basis of e	examination and/or in	th occurred at the ti	me, date and place opinion, death occu	and due to the caus arred at the time, date	se(s) and manner a and place, and du	as stated. ue to the cause(s)
April 18, 2005		withii To the comp	ž	29b. Signature and title of certifier	1) -	11	29c. Licens	se number	29d.	Date signed (Mor	nth, Day, Year)
Inpluz 10, 2005				> ( & & Van	Kois	Clin W.	10 D5/17/10	)	Λ == =	-11 10 O	2005
1 - 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		4		30. Name and address of person who co	ompleted cause of dea	ath (Ite and) (Type		,	Apr	TT 10, 2	.005
J. Allen Reilly, MD, 801 Tollhouse Avenue, D-1, Frederick, Maryland 21701		7					•	-1. Fred	erick. Mar	vland 2	1701
State Registrar APR 2 2 2005  Registrar Prinature			- 3	31. Date filed (Month, Day, Year)	Registrar	el nature	AL)	_,		J 2	

			1 - For State Registrar	State of Man	yland		artment tificate			nd Me		giene	2 11 11	5	1376	Management
	Physici	an	1. Decedent's Name (First, Middle, Last ERNEST F. DIO								Date of De		v. Ye	ar	3. Time of Death	
	/Medic	al	4a. Facility Name (If not institution, give				4b. City, To	NAME OF LO	ocation of I		PRIL	. 14		5	6:00A	M —
	≥xamiii	er	MARINER HEAD	TH OF 1	3EL	ATR	R	F).	AI	R		40		-	ORD	
	Funeral		5. Social Security Number 6. Se		n yrs. las <b>7</b> 8	t birthday)	If Under 1		f Under 24 Hours		Date of Bir	th LX <i>Xear)</i>	9.	Birthpla	ace (State or Foreig	ign
	Director		Usual Residence of Decedent	J.W. 2-11	, o	Yrs.				9	/28/1	926		Mary	land	_
	ryland		10a. State 10b. County		Oc. City,	Town or Lo								10	d. tnside City Limit	
	Ba-f s	ecto	MD Harfor	a		Str									1 ☐ Yes 2 🛣 N	10
	within 72 hours after death with the Maryland ene. than "natural", or Itams 23a or 28a-1 show Ita Madical Examiren raust be neithed at	<b>Funeral Director</b>	10e. Street and Number 3110 Queens Cast	le Court			10f. Žip Ci	ode 2115	4			10g. Cit	izen of Wha	t Count	ry?	
	ams 2	nera	11. Marital Status	12. Was Decedent Eve	r in U.S.	13. V	Vas Deceder Yes, specify	nt of Hispa	anic Origin	? (Specif	y Yes or No		14. Race - A			
36	s after	by Fu	1 Never Married 2 X Married 3 Widowed 4 Divorced	Armed Forces?  1 XYes 2 No If Yes, Give WW Year or Dates:	VII	1	Yes 2		Specify:	deito Mig	an, etc.)		Btack, V Specify:W			
21215-0036	2 hour	ted t	15. Decedent's Edu	cation		16a. Deced	lent's Usual (	Occupation	on			16b. K	ind of Busine			_
2	ithin 7 ne. nan "n	Completed	(Specify only highest grad	Cotlege (1-4or 5+)	٠,		kind of work DO NOT use Fighte		ing most o	f working			ril Se		•	
	filed w Hygier other th	Col	1.7. Father's Name (First, Middle, Last)			.116 1	rigite		R Mother's	Name /F	irst, Middle			CATC	:e	_
/lan	should be nd Mental marked o	To Be	Edgar Dick					10			Fa1ke		Sumame)			
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene. Importants if item 27 is marked other than "natural", or Items 23e or 28e-f show any injury or other traumatic event, Ite Medical Experience and be notified at once.		19a. Informant's Name/Relationship (Ty Virginia L. Dick				g Address (S Queen							e, <i>Zip</i> (		
Baltimore,	es 1 a of Hea if item or othe		20a. Method of Disposition  1 X Burial 2 Cremation 3 F	1	20b. Plac	e of Dispos letery, crem	sition (Name natory or othe	of er place)		Date		20c. Lo	ocation - City	or Tow	m, State	
Ë	t. Pages rtment of intent: If its		' 4 ☐ Donation 5 ☐ Other (Specify)		Slat		le Cem			16/2	005	De	1ta, 1	PA		
Ba	permit. Departn Imports any inju		21. Signature of Funeral Service Licens	Torelul	1		Name and A		,	,Inc.,	600 Ma	in St	.,Delta	, PA	17314	
			23a. Part1. Enter the disease, or compl shock, or heart failure. List only or	cations that caused the	death.	Do not ente	or the mode o	of dying, s	such as ca	rdiac or re	espiratory a	rrest,			Approximate nterval Between	
>	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Mchastus	hic		11900	nt	MI	16n	י מוני	7		(	Inset and Death	5_
	Examiner			Due to (or as a co	onsequer	nce of):	,									
	ם ה	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a co	neupeano	nce of):										
_	and and II-trans	Examiner	that initiated events resulting in death) Last	Due to (or as a co	nsequer	nce of):										
8760,	cate be executed physician and the burial-transit			1	on obquo.	100 017.										
9	rtificati ng phy i as the	Medic	IE ECMALE.													_
Вох	The law requires that the death certifics tie has been signed by the attending proage 2 should be detached for use as it	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	3c. tf yes, outcome of p 1 ☐ Live birth 2 ☐	] Fetal de	ath 3 🗆	Ectopic pregr						23d. Date of Month		/ Pay Year	
o	the de ry the a	yslc	1 Yes 2 No 9 Unknown	4□Pregnant at time 9□Unknown	e of deat	h 5∐	Other (speci	ify)					74101111		. ou	
S, G	res that igned b	by Pl	Part II. Other significant conditions cor	tributing to death but no	ot resulti	ng in the un	derlying caus	se given i	in Part I.		23e. Did t	obacco L	ise contribut	e to the	cause of death?	
ord	w require been si should b									- ]	1 🗆 1	Yes 2	XNo 3□	Proba	oly 4 Unknown	n
Vital Records,	has b	Completed								_	24a. Was		24b. Were prior death	to com	sy findings available pletion of cause of	0
ta	Physician: The law r this certificate has t	a	25. Was case referred to medical						C Dlass of	Dooth (C	1 ☐ Yes	2 No	1 🗆 \		□ No	_
<u></u>	nysicia is cert direct	To B	examiner?	lospital: 1  Inpatient	2 🗆 ER	VOutpatient	3 □ DOA	04			theck only of 5 ☐ Resid		6 🗆 Other (S	pecify)		_
0 0	ing Pt		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Ye	ar) 28	Bb. Time of Intury		Injury at Work?			. Describe l					
Division of	Attsnd death ctor: / y the f	licat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury -	- At home	a farm stre	M et factory o		s 2 No	28f	Location (S	Street an	d Number of	Rural	Poute Number.	
2	s after s after al Dire	Certification:	4 Homicide determined	building, etc. (S	Specify)	, , , , , , , , , , , ,	ot, lactory, o	11100		201.	City or Tow			ribrari	louie rvuriber,	
	To the Hospital or Attending Physician: within 24 hours after deals To the Funaral Director: After this certification in the funeral director, to completely filled in by the funeral director, to	edical (	29a. Certifier (Check only one) Certifying Physical Examination (Check only one)	sician: To the best of m ner: On the basis of exa and manner stated.	aminatior	dge, death and/or inv	occurred at t estigation, in	the time, o	date and p	lace, and	due to the	cause(s) date and	and manner	as stat	ed. he cause(s)	
	To th within To th comp	Me	29b. Signature and title of certifier	د. ه			1	icense nu					e signed (Me		* .	
•			> XH-N	.D.			1	)34	165	2		Apr	,115	, 2	005	
_	10		30. Name and address of person who co	mpleted cause of death	litem 23	3a) (Type, F	AVINI	ne	1311	A	) ~ !	Ma	rylan	d	2101Y	
	Sta Registr		31. Date filed (Month, Day, Year) APR 2 2 2005	2. Registrar's	Signatur	Spee	الميكا								· · · · · · · · · · · · · · · · · · ·	

ERNEST F.

# Director the Maryland with Baltimore, Maryland 21215-0036

**Funeral** 

item 27 is marked other than "naturel", or items 23a or 28a-f show other treumatic event, the Medical Examinar must be notified at permit. Pages 1 and 2 should be filed within 72 hours after a Department of Health and Mental Hygiene. Important: if item 27 is marked other than "naturel", or flem any injury or other treumatic event, the Medical Exercited 2008. Completed Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 12 17. Father's Name (First, Middle, Last) Be Lloyd McGee Edna ٥ 19a, Informant's Name/Relationship (Type, Print) Mark S. Dobridge / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crem. 4/7/05 21. Signature of Funeral Service Licensee 22. Name and Address of Facility neu Heath my carded Interchan Due to (or as a consequence of): Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit Due to (or as a consequence of) attending physician Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months Rosemall 4☐Pregnant at time of death 5 Other (specify) Records, P.O. detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Dequerion Completed has certificate **Division of Vital** 25. Was case referred to medical examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 2 this filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death After 1 Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident Director: 6 ☐ Could not be 3 🗋 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 [ Homicide within 24 hours a To the Funerel I

2005

1 - For Steta Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month Day **Physician** APRIL 0927 AM 2005 Dobridge Rosemary /Medical 4a, Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Healthcare Himor If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours Min. 1 ☐ M 2 😿 F Months 171-20-7036 March 15 1927 Pennsylvania Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director Baltimore Baltimore Md. 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 4519 Manor View Road 21229 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. ☐Yes 2X No f Yes, Give 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: ð White 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Own Home 18. Mother's Name (First, Middle, Maiden Surname) (Unknown) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2710 Plyers Mill Road, Silver Spring, Md. 20902 20c. Location - City or Town, State Alexandria, Va. Muriel H. Barber Funeral Home P. O. Box 5038, Laytonsville, Md. 20882 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 2 40-1 Arteroscience condocascie Difente 23d. Date of delivery Month Year Day 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Linknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No 1 Yes 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Centifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 29d. Date signed (Month. Day. Year 29b. Signature and title of certifier April 06, 2005 136-58489KIE st Agree Hospin, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MI 900 Coton Robert Aune Crunhall 31. Date filed (Month, Day, Year) 32. Reistrar's Signature State 07

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Registrar

7 24 1

2

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death APRIL Day 2005 ear **Physician** RALPH FRANKLIN DUTROW 8, 8:12A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FREDERICK FREDERICK MEMORIAL HOSPITAL FREDERICK If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1**∏**M 2□F Director 218-38-1808 10/1/1942 Maryland Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location worle 10b. County 10d. Inside City Limits r than "natural", or itema 23a or 28a-f ehov the Mazical Examiner must be notified at **Funeral Director** 1 ☐ Yes 2 ☑ No Maryland Frederick Keymar 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12223 LeGore Road 21757 United States hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Race - American Indian Black, White, etc. 1 X Yes 2 □ No If Yes, Give Year or Dates: 1968 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry filed within 72 Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Truck Mechanic Ith and Mental Hygie 27 is marked other traumatic event, II Concrete Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 99 Franklin Dutrow, Sr. Pages 1 and 2 should Ralph Rosabelle Stone 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) if item 27 i Nancy L. Dutrow/ Wife other 12223 LeGore Road, Keymar, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ØCremation 3 ☐ Removal from State ä \* 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory | 4/9/05 Smithsburg, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 1201 North Market Street, Frederick, MD 21701 ict 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) lancreatic **Physician** Can car mo. /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): attending physicisn Physician/Medical the as IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) the detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by pe 2 No 3 Probably 4 □Unknown 1 ☐ Yes 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 \( \times \) Yes \( 2 \times \) No page 2 2 No 1 Yes director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 ☐ Inpatient 2 ☐ R/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 100 Certification: To this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After or Attending Natural 5 Pending after death. 1 ☐ Yes 2 ☐ No 2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral I Hospitai 29a. Certifier Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) -9-05 105 X) Name and address of person who completed cause of death (Item 23a) (Type, Print) ev. Woodshow Geno Ash 10200 premine bistrar's Signature, 2005 State Registrar

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month ! Year Physician 05pm ne 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner -2 Towit Street FOSTON
If Under 1 Year If Under 24 Hrs. bot 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral 8. Date of Birth (Month, Day, 28-33 1 □ M 2 1 F Months Days Hours 217-28-351d Usual Residence of Decedent Director Mari 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits or iteme 23a or 28e-f ehor 77 is marked other than "neturel", or items 23s or 28s-f shor freumstic event, the Medical Examiner must be notified as albut 1 2 Yes 2 □ No Completed by Funeral Director permit. Pegea 1 and 2 should be flied within 72 hours after death with the It Dapartment of Heelth and Mantel Hyglene. Important: If Item 27 is marked other than "neturel", or Items 23s or 28s-1 any injury or other treumatic event, the Madical Examination 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Street Te 60 To 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baitimore, Maryland 21215-0036 1 Yes 20 No Specify: Specify: 3 DWidowed 4 □ Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Line Worker 1am 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ Jrace 19b. Mailing Address (Street and Number or Rural Route Number City or Town, State, Zip Code) Easton, Maryland 2/601

Date | 20c. Location - City or Town, State nomas Jowite 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 DBurial 2 ☐ Cremation 3 ☐ Removal from State Cemetery 4 14/05 Woodlawn \* 4 Donation 5 Dother (Specify) Easton, Maryland 22. Name and Address of Facility
HENRY FUNERA 21. Signature-of Funeral Service Licensee Home, Sticambridge, MD. Washington 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Preumonia Physician 2 4 2.26 /Medical Due to (or as a consequence of): Examiner CONTESTIVE hexit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificete be executed signed by the attending physicien and deedeched for use as the burial-trensit renal Chonic Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? cete has been sig , page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Únknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 22No certificete 1 ☐ Yes 2 ☐ No 1 Yes To the Funeral Director: After this certific completally filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide within 24 hours after To the Funeral Dire 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 00951172 4-8-55 MO

Registrar
DHMH 17 Rev 1/2001

State

21601

Jorge Abrego, MD, 598 Cynwood Drive, Suite 104, Easton, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, App Real 1 1 2005 32. Resitrar's Signature

DHMH 17 Rev 1/2001

Registrar

Maryland 21215-0036

timore.

Division of Vital Records, P.O. Box 68760.

		1 - For State Registrar	State of Man	•	artment of He rtificate of De			giene Reg. No.		
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/Med Exami		4a. Facility Name (If not institution, gi		ı ullel	4b. City, Town, or Lo	ocation of Dea	APRIL th	4c. County	2005 of Death	1506
Exqitti		MEMORIAL HOSPITA			CUMBERLA	ND		ALLE	CANV	
Funera		5. Social Security Number 6.	Sex 7. Age (//	n yrs. last birthday)	If Under 1 Year   I	f Under 24 Hrs	8. Date of Bir	th		lace (State or Foreign
Director		214-05-8601 Usual Residence of Decedent	<sup>1□ M 2</sup> X <sup>F</sup> 87	Yrs.	Months Days	Hours Min	8. Date of Bin Month, Da Feb 7,	1918	Cour	MD
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permit. Pagas 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23s or 28a-f ehow eny injury or other traumatic event, the Medical Eventiner must be retilled at once.	y Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 ★ Widowed 4 □ Divorced	12. Was Decedent Eve Armed Forces? 1  Yes 2 No If Yes, Give		Was Decedent of Hisp If Yes, specify Cuban, 1 ☐ Yes 2 No	anic Origin? (S Mexican, Puer Specify:	Specify Yes or No rto Rican, etc.)	- 14. Rac Bla Specif	ce - Americ ck, White,	etc.
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Pagas ment of I ant: If its ury or o		'4 □Donation 5 □ Other (Spec	THOUGHT IN STATE	Sunset Men			4/20/2005	Cumbe	erland	MD
permit. Pagas 1 and Department of Health Important: if item 27 eny injury or other tr once.		21. Signature of Funeral Service Lice	A M	1 22	2. Name and Address of Scarpelli F		lome, PA le: Cumber	land MD	21502	
		23a. art1. Enter the disease, or cor shock, I heart failure. List only	nplications that caused the	e death. Do not ent	er the mode of dying,	such as cardia	c or respiratory ar	rest,	21002	Approximate Interval Between
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death cert e attending d for use	Physician//	in the past 12 months?	1 Live birth 2 ☐ 4 Pregnant at tim		Ectopic pregnancy Other (specify)					Day Year
that the de led by the s detached t	hysi	9 Unknown	9□ Unknown							
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quire an sig uld b							1 🗆 1	res 2□No	3 Prob	ably 4 □Unknown
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<u>8</u> .g	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 🗹 Inpatient	2 ER/Outpatien	t 3□ DOA Other:	4 Nursing H	Home 5 ☐ Resid	ience 6 □Oth	er (Specify	)
ding Ph h. After th funeral	0.00	27. Manner of Death 1 ☑ Natural 5 ☑ Pending	28a. Date of Injury (Month, Day Ye	28b. Time of Injury	28c. Injury at Work?			ow injury occur		
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		30. Name and address of person who	completed cause of deati	(Item 23a) (Tyne	D36766	0		//		
b		VIK POONAI, M.D.	924 SETON D		MBERLAND, N	MD 2150	12			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🛭 🕦 🕤 1 - For Stata Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 300 Za 05 /Medical 4b, City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number, **Examiner** Wicomico CO 20 -5. Social Security Number 220-60-0960 If Under 24 Hrs. 8. Date of Birth (Month, Day, June 18 If Under 1 Year 9. Birthplace (State or Foreign 7. Age **Funeral** Days Months 157M 2□F Mary Land Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County treumatic evant, the Medical Examinar must be notified at 1 Yes 2 No Funeral Director Maryland Dorchester Cambridge 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 21613 204 307 Meteor Avenue **USA** 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Specify: Spanish-1 Never Married 2 Married 1 les 2 No Baltimore, Maryland 21215-0036 ö Specify: Be Completed by 3 Widowed 4 Divorced Portuguese Other 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry then Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. Horticulturist s 1 and 2 should be filed wi f Health and Mental Hygien item 27 Is marked other th Horticulture 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Roger G. Gonzales ပ Kathryn Robison 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jillrosalie E. Coale-Gonzales/Spouse 204 307 Meteor Ave., Cambridge, MD 21613 Health tem 27 item 27 othar t 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 jo 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State = 5 Department of Importent: If any injury or ' 4 ☐ Donation 5 ☐ Other (Specify) MidShoreCremationCenter 4-8-2005 Cambridge, Maryland 22. Name and Address of Facility Mid Shore Cremation Center, P.O. Box 1464, 21. Signature of Paneral Service License Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or rear failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 20 years Lumor /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) Records, P.O. the 9 Unknown 9 🗌 Unknown à signed to 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 ☐ Probably 4 ☐Unknown 2 No 1 TYes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No

The law requires that the death certificate be executed certificate has Division of Vital the Hospitel or Attanding Physician: 2 After this Certification: death. Director: after

autopsy perform 25. Was case referred to medical 26. Place of Death (Check only one) examiner' examiner?
1 Tes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 apatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 T Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

State Registrar

cal

(Check only one)

29b Signature

MD

30. Name and address of person who completed

cause of death (Item 23a) (Type, Print)

SASTAL

29c. License number

26278

29d. Date signed (Month. Day Year)

within 24 hours a

		1	For State Registrar	State of Ma		artment of He			ene	) m	100000
	Physici /Medio		1. Decedent's Name (First, Middle,	VI Hall				2. Date of Death Month	24	à nns	3. Time of Death O
	Examin		4a. Facility Name (If not instrution,	give street and number)	Lake	4b. City, Town, or L	ocation of Death	D	4c. County	of Death	)
	Funeral Director		5. Social Security Number  3 - 6 - 8437  Usual Residence of Decedent	Sex 7. Age	(In yrs. last birthday,	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Month, Day, 1	(ear) 1923	9. Birthplac Country	ce (State or Foreign /)
	Maryland -f show	tor	10a. State 10b. County	/An . C .	10c. City, Town or L	ocation			<b>,</b>	10d	I. Inside City Limits
	h with the 23a or 28a st be noti	al Director	10e. Street and Number 4199 S. U.	Der Ferr	u R-1	10f. Zip Code 2/86	22	100	p. Citizen of W	hat Country	17
36	n 72 hours after death with the Maryland "naturel", or Items 23e or 28e-f show valual Expriment was be notilised at	by Funeral	11. Marital Status  1 Never Married 2 Marrie	If Yes, Give	ever in U.S. 13.	Was Decedent of Hisp If Yes, specify Cuban,		cify Yes or No- lican, etc.)		- American k, White, etc	
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altimore, Ma	of Healt fitem 2		20a. Method of Disposition  20a. Method of Disposition  20a. Method of Disposition  30a. Denastion  50a. Other (Sp.)	3 □Removal from State		osition (Name of matory or other place)	maker	ate 20	c. Location -	Cly or Town	n, State
Baltir	permit. Pag Department Importent: I any injury o once.		21. Signature J Funeral Service Li		Triendsh.	2. Name and Address	of Facility	17/1/	Tschell	ast 1	50/15607 ND21801
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f Vital	Physicien: The this certificate ral director, pag	To Be	25. Was case referred to medical examiner?  1  Yes  No	Hospital	nt 2 ☐ ER/Outpatie	Othor	26. Place of Death 4  Nursing Hom		ce 6 🗆 Othe	or (Specify)	
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	/Medic Examin	al	4a. Facility Name (If not institution, give			4b. City, T			of Death		4c. C	ounty of Dea	th	
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ı	Funeral Director		578-32-9753	□M 2 <sup>M</sup> F 86	Yrs.		Days	Hours	Min. Ja	Date of Birth (Month, Day)	191	9 Vir	thplace (State of ountry) ginia	
	/land	-	Usual Residence of Decedent  10a. State 10b. County	_	Town or Lo								10d. Inside Ci	*
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	with the	Dire	10e. Street and Number 10450 Lottsford F	Road #1204		10f. Zip (	0715					ed Sta		
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "natural", or Itema 23a or 28a-f ehow any Injury or other traumatic event. Ite Medical Exam mer must be notified at once.	by Funeral Director	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2仏 No If Yes, Give Year or Dates:	ĺ	Was Decede f Yes, special	-	spanic Origin, Mexican		y Yes or No- can, etc.)		1. Race - Ame Black, Whi Specify:		
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2	(6)		30. Name and address of person who Alain G. Champal				oro	Pike	Upper					
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			1 - For State Registrar	State of Mai			Health and	Mental Hyg	_	13770
	Dhuain		1. Decedent's Name (First, Middle, Last	)				2. Date of Dea Month		3. Time of Death
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0	(4)		30. Name and address of person who co		th (Item 23a) (Type,					
_	9		DR GARY LITTLE	3001 H		DRIVE	CH	KEVERLY, A	1D 20785	
	Sta		31. Date filed (Month, Day, Year)  APR 1 2005	Registrar's	Signature	-		7		
	Registr	ar	WELL TELL FOOD	Delve	At Cos					

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d Hygin other, and, and, and, and, and, and, and, and	3	5th 17. Father's Name (First, Middl	e, Last)			1	Homemal			îrst, Middle, Ma	iden Sumame)		
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Baitimore, sermit. Peges 1 ar Department of Hee mportant: If Item any injury or other most.	1	20a. Method of Disposition  1 ☑ Burial 2 ☐ Crematio  4 ☐ Donation 5 ☐ Other			State		oosition (Name of ematory or other pla on Nat'l (		Date 4/19/0		c. Location - Ci		
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ds, Pulres that	a by L	Part II. Other significant cond			eath but	not resulting in the	underlying cause g	iven in Part	t I.			ute to the	cause of death?
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Vital F	0	25. Was case referred to med examiner?	cal	Hospital:		-55-0	-7 0			Check only one)		(C===:6-)	
To the Hospital or Attanding Physician: The lew requires that the deeth cerwithin 24 hours effer death. To the Funaral Director: After this certificate has been algned by the attending completely filled in by the funeral director, page 2 should be detected for use	Certification; 10	Z   MANGOIIL	ding stigation	28a. Date (Mor		Year) 28b. Time Injury	of 28c. Inju	uryat ork? ∐Yes 2[	28¢	Describe how     Location (Stre	injury occurred	i	
DIVI		4 🗍 Homicide dete	benimed	build			street, factory, office			City or Town,	State)		
a Hospi 24 hou a Funar letely fill	Medical	29a. Certifier 158 Certifier (Check only one)	ying Pn al Exan	niner: On the	basis of e	xamination and/or	ath occurred at the investigation, in my	opinion, de	and place, and eath occurred	at the time, dat	e and place, an	d due to t	ਸ਼ਰਹੇ. the cause(s)
To th To th comp	N.	29b. Signarure and title of cert	ifier					865	- *	A1	RILI	Month, D	oos
2 (2)		30. North address of pers	on who	0. 80	009	ath (Item 23a) (Typ SECON	1D AVE	NUE,	#404	B SIL	VBR ST	RING	9 MD20911
State Registra		31. Date tiled (Month, Day, Ye APR 11.	ar) 2005	E.	Registrar	's Signature	nets)	,					1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rag. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 14, 2005 2338 PM COCKEY HOUCK SARAH /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** Upper Chesapeake Medical Center Bel Air Harford If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) 8/27/1913 Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🛣 F Months Days Hours Min. **Director** 21**3-**36**-**8973 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-1 ebow treumatic event, the Madical Examinar must be notified at 1 ☐ Yes 2 No Funeral Director MD. Baltimore Monkton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 15931 Irish Avenue 21111 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 12 should be filed within 7 h and Mental Hygiene.
7 Is marked other than "r Elementary/Secondary (0-12) College\_(1-4or 5+) Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Thomas Dye Cockey Miller Mable 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 : Depertment of Health ar Importent: If Item 27 is any injury or other treu Thomas H. Houck /Son 15931 Irish Ave. Monkton, Md. 21111 Baltimore, 20a. Method of Disposition
1 □ Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 4 Donation 5 Other (Specify) Carroll Cremation 4/18/05 Hampstead, Maryland 21. Signature of Funeral Service Linentee 22. Name and Address of Facility Jarrettsville, Maryland E.G. Kurtz & Son Funeral Home, P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on pach line. Immediate Cause (Final disease or condition resulting in death) Failure. Heart **Physician** , ungestive /Medical Due to (or as a consequence of): Examiner 40 Cardial Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Physician/Medical IF FEMALE: Box 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 10

9 Unknown Month Year Day 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown Part II. Other'significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ DEITENSIUM 1 Yes 2 No 3 Probably 4 Nunknown Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 Å No 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No of Vital 25. Was case relerred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 ☐ Yes 2 No 27. Manner of Death 1 X Natural 2 ☐ Accident 28b. Time of Injury 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Tes 2 No 3 🗌 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ō within 24 hours a To the Funerel I 1) Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one)

Registrar DHMH 17 Rev 1/2001

State

5

500

32. Registrar's Signature

Upper Chesapeale

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Devetz

Antomette

31. Date filed (Month, Day, Year)

APR 2 2 2005

29c. License number

MD 0047631

29d. Date signed (Month, Day, Year) 4/16/05

ROGER HORNSBY 05-02468 RKD

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

			1 - State Unpend Item 2								ental Hyg		_	
	Physici	an	Decedent's Name (First, Middle, Last)     ROGER ALAN HORNSB								2. Date of Dea Month APRIL			3. Time of Dealth 3 5:30P. M
	/Medic Examin		4a. Facility Name (If not institution, give s SCHUMAKER POND					Town, or ISBU	Location o	of Death	ATKIL	4c.	County of Death	J. 301.
	Funeral Director		5. Social Security Number 6. Sex 215-90-4959 Usual Residence of Decedent	M 2□F	36 (In yrs. I	ast birthday) Yrs.	If Under Months	1 Year Days	If Under a	24 Hrs. Min.	8. Date of Birtl (Month, Da) AUG • 30	, Year)	9. Birth Cou MARY	place (State or Foreign ntry) LAND
5	Maryland I-f show fied at	tor	10a. State 10b. County MARYLAND WICOMICO			y, Town or Lo	cation							10d. Inside City Limits 1∭Yes 2 □ No
2	with the	i Director	10e. Street and Number 710 SOUTH PARK DRIV	/F			10f. Zip	Code 1804				10g. Cit	izen of What Cou	ntry?
036	J within 72 hours after death with the Maryland jiene. I than "natural", or Itams 23a or 28a-1 show It a Medical Examiner must be notified a	by Funerai		2. Was Decedent E Armed Forces? 1  Yes 2 N If Yes, Give Year or Dates:				ent of Hi	spanic Orig n, Mexican	gin? (Spe i, Pu <i>e</i> rto	cify Yes or No- Rican, etc.)		14. Race - Amer Black, White Specify:	
Maryland 21215-0036	within 72 ene. than "nai	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)		+)	life. I	dent's Usua kind of wor DO NOT us ALL F	k doné d e retired,	uring most	of worki	ng		ind of Business/Ir	
land 2	otha vant,	To Be C	17. Father's Name (First, Middle, Last) ROGER COSTON HORNS	3 <b>Y</b>			- '				(First, Middle, ELAINE	Maiden	Sumame)	
, Mary	and 2 should brath and Ment 127 is marked er traumatic e		19a. Informant's Name/Relationship (Type ROGER C. HORNSBY/F									-	or Town, State, Zi	
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Mente Important: If Itam 27 is marked any injury or other traumatic e <u>once</u> .		20a. Method of Disposition  1 X Burial 2 □ Cremation 3 □ R  4 □ Donation 6 □ Other (Specify)	emoval from State	C	lace of Dispo emetery, cren TTSVIL:	natory or ot	ther place			2005 F		SVILLE,	own, State  MARYLAND
Balt	permit. Departi		21. Sign turn of Frineral Service Liberse	Till	e			FUN LD O	ERAL CEAN	HOME CITY			X 3171 ISBURY M	D 21802
	Pnysician		28a. Pard. Enter the disease, or comblishock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	cations that caused e cause on each lin	the death e.	n. Do not <i>e</i> nt	er the mode	e of dying	, such as	cardiac o	r respiratory ar	rest,		Approximate Interval Between Onset and Death
	/Medical Examiner	<u>.</u>		Due to (or as a										
1,092	te be executed ysician and te burial-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause 1 that initiated events resulting in death) Last	Due to (or as a				<u>-</u>						
.O. Box 68	death certifica e attending ph id for use as th	Physician/Medio	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 ☐ Fetal	death 3	Ectopic pre						23d. Date of deliv Month	ery Day Year
s, P	98 Ded	by	Part II. Other significant conditions con	tributing to death bu	ıt not resu	ulting in the u	nderlying ca	ause give	n in Part I.			bacco u		he cause of death?
I Record		Completed									24a. Was a autop perfor	sy	prior to co death?	opsy findings available impletion of cause of
Vital	Physician: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner?	ospital:	- 20	ED/Outs still		A Othe	APP.		(Check only of			, DOMD
ion of	ding After fune	on: I	27. Manner of Death  1 Natural 2 Accident  2 No  1 Pending investigation	28a. Date of Injur 4 (80n) Say	v	ER/Outpatien 28b. Time of 4章母男 found	21	8c. Injury Work	4   140	2	ne 5 Hesid 28d. Describe h		6 <b>X</b> ther (Speci y occurred	w POND unk
Division	P Pi F	Certificati	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Inju- building, etc. <b>pond</b>	iry - At ho :. (Specify	ome, farm, str	eet, factory	, office		W	28f. Location (S City or Tow icomico	treet and n. State	Schumber or Rur Schumak unty, Ma	er Pond, ryland
	the Hospital hin 24 hours tha Funaral I	edical	29a. Certifier 1 ☐ Certifying Physical Check only one) 2 ☐ Medicel Exemination	icien: To the best of ter: On the basis of and manner sta	examinal	wledge, death tion and/or in	vestigation,	in my op	inion, deat	d place, a th occurre	ed at the time, o	date and	1 place, and due t	o the cause(s)
)	with To	M	29b. Signature and title of certifier	Ky-	-w	>		. License					te signed (Month,	Day, Year)
			30. Name and address of person who co	ing				ENN S	STREE	T,BA	LTIMORE	MAI	RYLAND 2	1201
	Sta Registi		APR 1 2 2005	Registra	irs Signa	ture day	· Co							

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 3:25 p Aphonth 8, D2005 рм **Physician** DUEY LEE HIPPEARD Sr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Civista Medical Center LaPlata, MD Charles If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) AUG 20 1938 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral**  Birthplace (State or Foreign Country) 1√2 M 2□ F 66 Director 226-44-0991 Virginia Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Event at must be notified at 1 ☐Yes 2 ☐ No Be Completed by Funeral Director Maryland St Mary's Mechanics ville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 30045 Cochise Court 20659 USA Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. Int: If item 27 Is marked other than "natural", or Items 23. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Yes 27 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Salesperson 11 Food 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Preston Hippeard Virginia Hippeard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Duey L. Hippeard Jr. (Son) 9884 Hagel Circle Lorton, Virginia 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages:
Department of H
Important: If ite
any injury or ot 1 → Burial 2 □ Cremation 3 □ Removal from State Trinity Memorial Gardens 4-12-05 Waldorf, MD \* 4 ☐Doption 5 ☐ Other (Specify) 22. Name and Address of Facility Eberwein Funeral Services M00173 4433 White Pls. I.a. White Pl Att. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ock, or heart failure. List only one cause on each line. 4433 White Pls. La. White Pls., MD 20695 Approximate Interval Between Onset and Death Impediate Cause (Final disease or condition resulting in death) Priysician LUNG CANCER /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? 4□Pregnant at time of death 5 Other (specify) P.O. Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, DNGESTIVE 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24a. Was an autopsy performed? BETES - TYPE 24b. Were autopsy findings available prior to completion of cause of death? PERIPHERAL 1 ☐ Yes 2□ No 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To 28c. Injury at Work? 27. Manger of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending Injury after death. Director: Af 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 29b. Signature and title of gertifier 29c. License number 29d. Date signed (Month, Day, Year) D-26064 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Vidyasagar Anmangandla, MD PO Box 282 Charlotte Hall, MD 20622 31. Date filed (Month, Day, Year) APR 1 1 2005 32. Redistrar's Signature Registrar

ppea

/sicia		1. Decedent's Nan Linda	ne (First, Middle,	Last)		lse	r					2. Date of D Month APRIL	Da		Year	3. Time of	
ledica amine	al er j	4a. Facility Name CUMBERLAI	(If not institution,		and number)		1			Location o	f Death	AFKIL	4c.	. County o		12:25	a
		5. Social Security		6. Sex		AL. ge (In yrs. la:	st birthdav)	If Under	MBERI 1 Year	If Under:	24 Hrs.	8. Date of B		LLEGA		lace (State o	r Foreign
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=		Usual Residence	10b. County			, ,	Town or Lo		al						1	0d. Inside Cit	ty Limits
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L L	uner	11. Marital Status	rried Ž∏ Marnie	l A	Vas Decedent	?	S. 13.	Was Deced	ent of His	spanic Orig n, Mexican	gin? (Spe , Puerto	cify Yes or N Rican, etc.)	0-		- Americ c, White, c	an Indian, etc.	
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Andica	Completed		15. Decedent's ecify only highest	grade con	npleted)		(Give	dent's Usua kind of wor DO NOT us	rk done di	uring most	of worki	ng	_	ind of Bus			
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any injury or other traumatic event, It is Mudical Exercises must be notified at once.		19a. Informant's I	Name/Relationshi	ip <i>(Type, F</i>	Print) Siste	r	19b. Mailii	ng Address Mario	(Street a	n <i>d Numb</i> e	r or Rura	I Route Numi Cum	per, City o	or Town, S		<sup>Code)</sup>	2
othar	1	20a. Method of Di	isposition			20b. Pla	ace of Dispo	osition (Nam	ne of		D	ate	,	ocation - C			
ury or			2  Cremation : 5  Other (Spe		val from State		pelli Fu				4	/22/2005	Cre	esapt	own	М	D
any in		21. Signature of F	Funeral Service Li	icensee	1 1		04	Name and	d Addrage	s of Facility							
			ソフリノレ	J (	Jh/1.	MM	24	2. Name and SCA							4500		
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			1 - For State Registrar	Otato of	iviai y tai		tificate				Reg. No.	05	13776
I	D		1. Decedent's Name (First, Middle, L	ast)						2. Date of Dea Month		Yeer	3. Time of Death
	Physicia /Medic		Barbara H. Joh							April	6	2005	03:43 A M
	Examin	er	4a. Facility Name (If not institution, gr				4b. City, To		tion of Death	i		y of Death	
	Funeval		Laurel Regiona  5. Social Security Number 6.			last birthday)	If Under 1	Laure Year If U	e L nder 24 Hrs.	8. Date of Birt	h		e George's
	Funeral Director		578-64-9117	1 ☐ M 2 ☐ XF	64	. V	Months	Days Ho	urs Min.	Oct. 25	y, Year)	Wa	place (State or Foreign intry) Sh., DC
	put *		Usual Residence of Decedent  10a. State 10b. County		10c Cit	y, Town or Lo	cation						10d. Inside City Limits
	Aaryla f sho	ō		0 1		y, 10W1101 E0		D.					1 X Yes 2 No
	28a-	Director	Maryland   Prince 10e. Street and Number	George's	3		10f. Zip C	Rivero	ате		10g. Citizen of	What Cou	intry?
	h with	ai Di	6325 Riverdale	Road				20	737		Uni	ted S	tates
	ems	Funerai	11. Marital Status	12. Was Decede		.S. 13.	Was Decede	nt of Hispan v Cuban, Me	ic Origin? (Spixican, Puert	pecify Yes or No- Dican, etc.)	- 14. Ra	ce - Ameri ack, White	ican Indian,
36	s afte	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 Tes 2 If Yes, Give Year or Date			1□Yes 2					ity: B1	
Maryland 21215-0036	filed within 72 hours after death with the Maryland Hygiene. ther then "natural", or Items 23e or 28e-f show int, the Medical Evarities must be notified at	ted t	15. Decedent's 1	Education	<b>35.</b>	16a. Deced	dent's Usuaf	Occupation			16b. Kind of I	Business/lr	ndustry
215	thin 73	Completed	(Specify only highest g Elementary/Secondary (0-12)	rade completed) College (1-4	or 5+)	(Give	kind of work DO NOT use	done during retired)	most of wor	king			,
2	led wi ygien ygien ygien ygien th	Con		2		I	o.c. s		Emplo				nment
and	d be find He other	Be c	17. Father's Name (First, Middle, Las	re Harris	,			18.1	Mother's Nan	ne (First, Middle, Maggie		,	
2	should ind Men s marke umatic	<sup>2</sup>	19a. Informant's Name/Relationship		,	19b. Mailir	ng Address (	Street and N	umber or Ru	ral Route Numbe			p Code)
	alth a	1	Kenneth Johnson	- Son		6325	Rive	rdale	Rd.,	Riverdal	e, MD	20737	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, the Medical Evertical interioral be notified at once.	ı	20a. Method of Disposition 1   ☐ Burial 2 ☐ Cremation 3	□ Removal from St	1 /	Place of Dispo	sition (Name natory or oth	e of er place)		Date	20c. Location	- City or T	own, State
Ĕ	Pages tment of I tant: If its jury or o		`4 Donation 5 Dother (Spec	cify)	Ft	Linco							od, MD
Bai	permit Depar Impor any in		21. Signature of Funeral Service Lic	1	1-111	- 22				tewart F			0010
			23a. Part 1. Enter the disease, or co shock, of heart failure. List on	MUSCU) mplications that cau	sed the deat	h. Do not ent				or respiratory ar		DC Z	Approximate
	Pnysician	Se III	fmmediate Cause (Final			ial Inf							Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	_ a	as a conseq								<del></del>
	Examiner	L	Sequentially list conditions,	b		y Artei	y Dis	ease					
	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events	Due to (or	as a conseq	uence or):							
Ć	te be executed ysician and ie buriat-transit	Exar	that initiated events resulting in death) Last	C. Due to (or	as a conseq	uence of):							
3760,		icai		<b>d</b>									
x 68	The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached lor use as the	by Physician/Med	IF FEMALE:	22a H vac autor	ma of pro-	2001							
Bo	attend lor us	cian	23b. Was decedent pregnant in the past 12 months?		h 2 ∏ Feta nt at time of d	ıl death 3□	Ectopic pred					ate of deliv Ionth	very Day Year
O.	t the d by the ached	hysl	1 Yes 2 No 9 Unknown	9□ Unknow									
S,	gned to	by P	Part II. Other significant conditions			ulting in the u	nderlying cau	us <i>e</i> given in	Part I.				lhe cause of death?
ord	w require been si	ted	Diab	etes Mell	itus			-		1 🗆 Y	res 2□No	3 Pro	bably 4 XUnknown
ဒ္ဓ	has be	Completed	Нуре	rtension						24a. Was autop	SV	prior to co	opsy findings available ompletion of cause of
a	ician: The certilicate rector, pag			pheral Va	scular	Disea	ase			1 Tes	rmed? 2∏ No	death?	2 X No
₹	s certil	To Be	25. Was case referred to medicaf examiner?  1 ☐ Yes 2 ☑ vo	Hospital:	nationt 2 T	ER/Outpatier	ot 3□ DO4			th <i>(Check only o</i> ome 5□ Resid		har /Spac	(6.1)
Division of Vital Records, P.O. Box	Attanding Physician: The lay rideath. r death. ector: Alter this certilicate has by the funeral director, page 2		27. Manner of Death	28a. Date of		28b. Time o		c. Injury at Work?		28d. Describe h			119)
Sion	sandir eath. or: Al	catic	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigat 3 ☐ Suicide 6 ☐ Could not	ion			М	1 🗌 Yes	2 □ No				
$\frac{1}{2}$	or Att	Certification;	4 Homicide determine	286. Place 0	f In <del>j</del> ury - At h g, etc. <i>(Specii</i>	ome, farm, sti fy)	eet, factory,	office		28f. Location (S City or Tox	Street and Num vn, State)	ber or Rur	al Route Number,
_	To the Hospital or Attan within 24 hours after deatl To the Funeral Director: completely filled in by the		29a. Certifier 1 Certifying I	Physician: To the b	est of my kno	owledge, deat	h occurred at	t the time, da	ite and place	, and due to the	cause(s) and n	nanner as	stated.
	he Ho in 24 h he Fu pletely	edical		aminer: On the bas and manne	is of examina								
	To the I	Σ	29b. Signature and title of certifier	602 -			29c.	License nun	ber		29d. Date sign	ed (Month,	, Day, Year)
	(1)		00.11-11-11	Links	*	- 00.1 =	D.1-11	D45	217		Apri	il 6,	2005
f	- (2)		30. Name and address of person wh  Adebowale Aj					d #4	15 (	College	Park. N	4D 21	0740
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	Regist	rar	APR 1 1 20	IS Albert	w 18	do	The same of the sa						

		-	State of Marylan	d / Depa		Health and M	Mental Hyg		005	13777
Physicia /Medic			YATT JOHNSON	N JR		40		5 20		3. Time of Death 1:40 P M
Examin	er	4a. Facility Name (If not institution, give str NATIONAL NAVAL M  5. Social Security Number 6. Sex				or Location of Death ETHESDA If Under 24 Hrs.	8 Date of Birth	Mo	ONTGOM	
Funeral Director			1 2□F 4		Months Days	Hours Min.	(Month, Day, 09-13-	Year) 1964	Wash	place (State or Foreign htry) nington, DO
Maryland I-f show fixd at	tor	10a. State 10b. County  Md. Prince G		y, Town or Lo Fores	cation tville				1	0d. Inside City Limits  XXYes 2 □ No
th with the 23a or 28s	al Director	10e. Street and Number 8716 Ritchboro	Road		10f. Zip Code	0747	1		of What Cour SA	itry?
permit. Pages 1 and 2 should be tiled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itams 23a or 28a-f show any injury or other traumatic avent, I're Madical Examinar must be multihad at Once.	by Funeral	11. Marital Status 12 1 Never Married 2 Married 3 Widowed 4 Divorced	Was Decedent Ever in U Armed Forces? 1XYes 2□N5/2 IfYes, Give Year of Dates: Pres	6/83	Was Decedent of I f Yes, specify Cub 1 ☐ Yes 2 ☐XNo	Hispanic Origin? (S ean, Mexican, Puerto Specify:	pecify Yes or No- o Rican, etc.)		Race - Americ Black, White, ecify: BI	
ithin 72 ho ne. nan "natul e Medical	Completed	15. Decedent's Educa (Specify only highest grade of Elementary/Secondary (0-12)	Completed) College (1-4or 5+)	(Give life. I		during most of wor nd)	king	16b. Kind o	f Business/Inc	
l be filed water Hygier the ad other the avent, In	Be	17. Father's Name (First, Middle, Last)  Reginal W. John	son Sr	S	ervicem	18. Mother's Nan	ne (First, Middle, M			1es
rd 2 should Ith and Me 27 Is mark traumatic	P.	19a. Informant's Name/Relationship (Type Shirley Childres	, Print(Mother)	5901 Wash	Clay Sington,	and Number or Ru treet, D.C.	-			Code)
ages 1 an ant of Heal it: If item 2 y or othar		20a. Method of Disposition  1X Burial 2 ☐ Cremation 3 ☐ Re  4 ☐ Donation 5 ☐ Other (Specify)	20b. F	Place of Dispo	sition (Name of		Date	20c. Locati	on - City or To	own, State
permit. F Departme Importar any injur		21. Signature of Funeral Service Licensee	11	767 R	Name and Addr alph Wi	ess of Facility 111ams omacave	Funeral	Ser	vice	DC 20003
Physician /Medical physician physici	ical Examiner	23a. Part1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or rignry that initiated events resulting in death) Last  d.	SEPSIS  Due to (or as a consec	quence of): ELL NO: quence of):	<u></u>	ng, such as cardiac		est,		Approximate Interval Between Onset and Death
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w requires that the de been signed by the should be detached	by	Part II. Other significant conditions cont	ributing to death but not res	sulting in the u	nderlying cause gr	ven in Part I.		oacco use d as 2 🎇 N		ne cause of death?
sician: The law rec certificate has bee irector, page 2 shoo	Completed						24a. Was a autops perform	y ned?	tb. Were auto prior to co death? 1 \( \subseteq Yes	psy findings available mpletion of cause of 2 XIO
Physician: this certific ral director,	o Be	25. Was case referred to medical examiner?  1 \sum Yes 2 \sum No	spital: 1 Inpatient 2	ER/Outpatier	nt 3□ DOA Ot	her	ath (Check only on lome 5 - Reside		Other (Specif	y)
Attanding Physician: r death. sctor: After this certific by the funeral director,	atlon: T	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Wo	ury at ork? Yes 2 No	28d. Describe ho	w injury oc	curred	
in Diffe	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci		reet, factory, office		28f. Location (St City or Town		umber or Rura	d Route Number,
To the Hospital within 24 hours a To the Funeral I completely filled	edical		cian: To the best of my knows: On the basis of examination and manner stated.							
To the I	M	29b. Signature and title of cortifier	F.	//		se number		9d. Date si	gned (Month,	
9 11/2		30. Name and address of person who cor	apleted cause of death (Ite		Print) NA	88648 (FL TIONAL NA	AVAL MEDI			2005
Str	ate	DAVID M. BRETT-M 31. Date filed (Month, Day, Year)	AJOR LCDR 32 Registrar's Sign			THESDA MI	20889-5	600		
Regist		APR 1 1 2005	Billian .	K L	2000					

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

			For State Registrar	State of Ma		id / Depa		of He	ealth and l			nns	13778
	· ·		1. Decedent's Name (First, Midd	le, Last)				-		2. Date of Dea	ath		3. Time of Death
	Physici /Medio		TERRENCE	JERO	ME		TOT.	INSON	V	APRTT.	Day ∩5	2005	8:34p M
	Examir		4a. Facility Name (If not institution						Location of Deat		~~	County of Dea	1th
14			WASHINGTON COU	NTY HOSPITAL			HAGER	STOL	IN		TATA	SHINGTO	777
	Funeral		5. Social Security Number	6. Sex 7. Ag	e (In yrs.	last birthday)	If Under 1	Year	If Under 24 Hrs.	8. Date of Birt	$\frac{1}{h}$		Thplace (State or Foreign ountry)
	Director		214-86-0442	1⊠M 2□F 36		Yrs.	Months	Days	Hours Min.	Novembe	$e^{r}$ 2	Was	hington,DC
	pu ,		Usual Residence of Decedent										
	anyla shoy	-	10a. State 10b. County			y, Town or Lo							10d. Inside City Limits
	Ba-f	5	MD Washi	ngton	H	agerst	own						1 XYes 2 No
	ith th	Funeral Director	10e. Street and Number				10f. Zip (				-	zen of What C	ountry?
	ath w	ral	1037 Login D	rive # F				217	40		U.S	.A.	•
	ar de	nne	11. Marital Status	12. Was Decedent Armed Forces?		.S. 13.	Was Decede If Yes, specif	nt of His y Cuban	panic Origin? (S , Mexican, Puert	pecify Yes or No- o Rican, etc.)		<ol> <li>Race - Am- Black, Whi</li> </ol>	
36	ours after death with the Marylar elf, or items 23a or 28a-f show Examinar must be notified at	by F	1 ☐ Never Married 2√2 Mai 3 ☐ Widowed 4 ☐ Divorce	If Yes, Give	10		1 □ Yes 2√		Specify:			Specify:	Black
21215-0036		g p				100 D	danda Harri	0					
쟌	n 72 "na	Completed	(Specify only highe	nt's Education st grade completed)		(Give	dent's Usual kind of work	done du	ion iring most of wor	king	16b. Ki	nd of Business	/Industry
7	with the the	m m	Elementary/Secondary (0-12)	College (1-4or 5	+)		enter	, , , , , , , , , , , , , , , , , , , ,			Pr	ivate	
Q	be filed within 72 ha ital Hygiene. id other then "natur event, he Mudical	Ö	17. Father's Name (First, Middle	Last)				1	18. Mother's Nan	ne (First, Middle,	Maiden	Sumame)	
an	d be ental ked c	To Be	Curtis Turne	er					Cynthi			,	
Maryland	shoul nd M mari	-	19a. Informant's Name/Relation	ship (Type, Print)		19b. Mailir	na Address (	Street an	nd Number or Ru	ral Route Numbe	r. City o	r Town State	Zin Code)
S	Pages 1 and 2 should be filed within 7 trent of Health and Mental Hygiene. tent: if Item 27 is marked other then "righty or other treumatic event, the Mad			on/Wife						rstown,	-		
စ်	Hea Hea tem othe	9	20a. Method of Disposition	,	20b. P	Place of Dispo emetery, crer	sition (Name	of .	#I Have	Date Date		y ±anu cation - City or	Town, State
Baltimore,	ages ant of t: If i		1 ⊠Burial 2 ☐ Cremation  4 ☐ Donation 5 ☐ Other (5		4				ery 4/12	/05		nton,Ma	
量	artme orten injur		21. Signatur of Funeral ervice		Res	T	Name and						ral Home
Ba	permit. Pag Department Importent: I any injury o	7	K C		_					Landove			
			23a. Part1. Enter the disease, o		the death							Tar y Tan	Approximate
	2 00		shock, or heart failure. Lis Immediate Cause (Final	only one cause on each lin	10.	7			1.00				Interval Between Onset and Death
	Pnysician /Medical	1	disease or condition resulting in death)	_ a	> Un		WO	IND	06 0	MEST			
	Examiner			Due to (or as	a conseq	uence of):							
		i i	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a conseign	uence of	-						
	uted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		7/								
-	be executed ician and burial-transi	xa	that initiated events resulting in death) Last	C. Due to (or as	a consequ	uence of):							
8760,	ate be executed hysician and the burial-transit	call		d									
.89	0 0	edic		0.									
Вох	eath certifi attending   I for use as	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome								3d. Date of de	liven
m	death a atte	cla	in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant at			]Ectopic prec ] Other <i>(spec</i>					Month	Day Year
P.O.	tt the deby the tached	hys	9 Unknown	9□ Unknown									
	s that ned b	by P	Part II. Other significant conditi	ons contributing to death be	ıt not resi	ulting in the u	nderlying cau	ise given	in Part I.	23e. Did to	bacco u	se contribute to	the cause of death?
rds	quires t n signe									1 🗆 Y	es 2	No 3 □ Pr	obably 4 Unknown
000	w require been sign should b	Completed								24a, Was a	/	24h Wore a	itopsy findings available
Re	0 5 0	E C								autop: perfor	sy	prior to death?	completion of cause of
a	icien: Th certificate rector, pag	S	25. Was case referred to medica	1							2 □ No	1 Sores	2 🗆 No
of Vital Records,		OB	examiner?  1XXYes 2 No	Hospital: 1 ☐ Inpatie	ot of	ER/Outpatien	t 3 DOA	Other		th Che k onl or		. C.O.I. 10	
of	g Phys ter this neral di	$\vdash$	27. Manner of Death	28a. Date of Injur	_	28b. Time of		. Injury a Work?	T I I I I I I I I I I I I I I I I I I I	ome 5 Residence 28d. Describe he			city)
on	를 는 옷 걸	tiol	1 ☐ Natural 5 ☐ Pendii 2 ☐ Accident invest		Year)	2000	. 14		s 2 No			CT WA	SSHUT
Division	Attending r death. sctor: After by the funer	fica	3 ☐ Şuicide 6 ☐ Could	sined 286. Hace of Inju	iry - At ho	me, farm, str					-		
ē	after Dire	Certification;	Homicide determ	building, etc	. (Specify	AT APARI			.0	City or Town	n, State)	7 6	1 NOLAND
	To the Hospitel or Attentwithin 24 hours after death To the Funerel Director: completely filled in by the	aic	29a. Certifier 1 ☐ Certifyi	ng Physician: To the best of	f my kno	wledge, death	occurred at	the time	date and place	and due to the	ause(s)	and manner as	stated.
	e Fu	edicai	(Check only 2 X Medicel one)	Examiner: On the basis of and manner sta	examinal	tion and/or inv	estigation, in	my opin	nion, death occu	red at the time, d	ate and	place, and due	to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifie		//		29c. I	License r	number	2	9d. Date	signed (Monti	h. Day, Year)
			1	1/1/1	1			CME		Δ	PRTI	06, 2	005
^	(1)	-	30. Name and address person	who completed cause of d	arth (Item	23a) (Type.		تست					
R	S		MARICA	MIPPLEN	P	,, JF-21	,	Pen	n Stree	t Baltim	ore	Marvla	and 21201
	Sta	te	31. Date filed (Month, Day, Year,	3 Registra	r's Signa	ture					,	- MAL J 10	THE PLANT
	Registr	ar	APR 11	LUUS Seem	, 18	And	de la						

			For State Registrar	State of Ma	aryland	-	artment of tificate of				giene Reg. No	4005	137	179
	Physici	an	1. Decedent's Name (First, Middle, L	ast)						2. Date of De	ath Da	y Year	3. Time of	
	/Medic		ANNIE LOU							APRIL	6	2005	5:45	РМ
	Examin	ner	4a. Facility Name (If not institution, g				4b. City, Town,		n of Death	1		County of Death		
			CLINTON REHABIL  5. Social Security Number 6.		nter e (In yrs. Ia:	st hirthday)	Clin		er 24 Hrs.	8. Date of Bir				v Foreign
	Funeral Director		237-56-8803	1□M 2X1E	67	Yrs.	Months Day			July 1	ay, Year)		place (State of intry) :h Caro	
	and	1	Usual Residence of Decedent  10a. State 10b. County		10c. City,	Town or Lo	cation						10d. Inside Ci	ty Limits
	should be filed within 72 hours after death with the Maryland nd Mental Hyglene r merked other than "natural", or Items 23a or 28a-f show umatic event, the Medical Examinat must be notified a	to	MD Prince	Geoege's	т.	argo							1X Yes	2 🔲 No
	r 28a	irec	10e. Street and Number	dedege 5		argo	10f. Zip Code	)			10g. Cit	tizen of What Co	untry?	
	th wit	Funeral Director	500 N Harry S.	Truman Driv	7e		20774				U.S	5.A.		
	ems ems	ner	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S	13.	Was Decedent of If Yes, specify Cu	f Hispanic C uban, Mexic	origin? (Sp an, Puert	pecify Yes or No o Rican, etc.)	0-	14. Race - Amer Black, White		
9	s afte	by Ft	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🐼 1 If Yes, Give Year or Dates:	No		1 □ Yes 2√2 N	lo Specif	y:			Specify: R1	ack	
3	hour		15. Decedent's			16a, Dece	dent's Usual Occ	cupation			16b. K	ind of Business/l		
2 2	n na	Completed	(Specify only highest of Elementary/Secondary (0-12)	grade completed)  College (1-4or 5	5.1	(Give	kind of work dor DO NOT use reti	ne during mo	ost of wor	king			,	
7	d with giene ar tha	E O	12th	College (1-40)	) <del>+</del> )	Day	Care Pr	ovide	r			Private		
2	al Hyg	Be	17. Father's Name (First, Middle, La	st)				18. Mot	her's Nan	ne (First, Middle	, Maiden	Sumame)		
ylalld	Ment Ment arked aric e	7	George Miles							ae Brid				
	C1 60 mm 60		19a. Informant's Name/Relationship Mary E. Gray/At									or Town, State, Z • Maryla	-	74
1)	1 and Health sm 27 ther tr		20a, Method of Disposition	TITC					illiaii .	Date La		ocation - City or		/ <del>-</del>
0	permit. Pages 'Department of H Important: If ite any Injury or ot		1 ⊠Burial 2 ☐ Cremation 3				esition (Name of matory or other p Memorial		0/- 1	2-2005		dover, M		d
Saltimor	artme ortani Injury		<ul> <li>4 □ Donation 5 □ Other (Special Signature of Funeral Service Lice</li> </ul>		IIali							s Funera	2	
Ö	Depa Impo any It		D. D. Nas	Lall								Maryland		
			23a. Part1. Enter the disease, or co shock, or heart failure. List on	emplications that caused	d the death.							riar y raine	Approximat Interval Bet	е
	Physician		Immediate Cause (Final disease or condition	Sepsis	110.								Onset and	Death
	/Medical		resulting in death)	Due to (or as	a conseque	ence of):				<u> </u>				
	Examiner		Sequentially list conditions.	<sub>b.</sub> Stroke										
T	ad sit	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as										
	and and II-tran	Examine	that initiated events resulting in death) Last	c. Hypert										
2/00	cate be executed physician and the burial-transit	dicai E		Diabet	is M	ellit	ıs							
200	ificate g phy: as the	edic		U										
X Q Q	leath certifica attending ph I for use as t	M/U	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			⊒Ectopic pregna	ncv				23d. Date of deli		
	0 0 0	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant a 9☐Unknown			Other (specify)					Month	Day	Year
r Ö	that the de led by the a detached t	Phy	9 Unknown  Part II. Other significant condition	e contributing to doub h	out not recui	Iting in the u	anderhving course	aives in Par	et I	23e Did	tohacco	use contribute to	the cause of o	Heath?
ŝ	The law requires that the tite has been signed by thoage 2 should be detache	l by	Dementia	s contributing to death t	out not resu	iting in the c	indenying cause	given in rai		1		□No 3□Pro		
Ö	w requires been signs should be	etec								24a. Was				
Vital Record	has ge 2	Completed by								auto	opsy formed?	death?	topsy findings completion of c	ause of
Ö		ပိ	25. Was case referred to medical					26 Pla	ace of Dec	1 ☐ Yes ath (Check only		1 Yes	21 No	
	Physician: r this certific ral director.	To B	examiner?	Hospital: 1 ☐ Inpati	ent 2 🗆 5	ER/Outpatie	nt 3 DOA	Othor				6 ☐ Other (Spec	city)	
10			27. Manner of Death	28a. Date of Inju (Month, Da		28b. Time o		njury at Vork?		28d. Describe				
ö	Attendin death. ctor: Aft y the fur	atio	1 XNatural 5 ☐ Pending 2 ☐ Accident investiga	tion	,	,,		☐Yes 2	□No					
Division	il or Attending Patter death. I Director: After I	Certification:	3 Suicide 6 Could no 4 Homicide determin		jury - At hor tc. <i>(Specil</i> y,	me, farm, st	reet, factory, offic	ce		28f. Location City or To	(Street allown, Stat	nd Number or Ru e)	ral Route Num	ıber,
_	urs af oral D											\ d		
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune.	edical		Physician: To the best caminer: On the basis of and manner st	of examinati									\$)
	To the within 2 To the complet	Me	29b. Signature and tile of certifier		10		29c. Lice	ense numbe	er		29d. Da	ate signed (Monti	n, Day, Year)	
)			) ( ZA	w	D/P	hysic	ian D	0053	3215	<b>\</b>	4	18/20	05	
P	_(4)		30. Name and address of person w				, Print)							
	0		Zafar Ansari				Road Wa	aldorf	, Ma	ryland	2060	2		
	St Regist	tate trar	31. Date filed (Month, Day, Year) APR 1 1 20	05 Some	rar's Signat	A Service	Se .							

anend item#5, per Imp. 843, printin Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician April** Mary Bertha Johnson 2005 12:15A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City Town, or Location of Death 4c. County of Death Examiner Cherry Lane Nursing Center Prince Georges Laurel If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 6. Sex **Funeral**  Birthplace (State or Foreign Country) 1 M 2 XF Director 80 <del>453-36-</del> 04/20/1924 Louisiana Usual Residence of Decedent the Maryland 10b. Count 10c. City. Town or Location 10a. State 10d. Inside City Limits 28a-f show ust be notified at MD Prince Georges Director Laurel 1 XYes 2 No 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ō 9001 Cherry Lane 20708 USA 238 death Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours atter of Hygiene. Hygiene. then "natural", or Ital 1 Never Married 2 Married ☐Yes 2X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 Yes 2 No Specify. þ Specify: Black 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education
(Specify only highest grade completed) 16b. Kind of Business/Industry Comple Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home s 1 and 2 should be filed wi I Health and Mental Hygien tem 27 Is markad other th 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Jones Susie Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20774 Norma Faye Legette/Daughter 13310 New Acadia Ľäħĕ,ÚpperMarlboro,MD If item 27 I 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 permit. Pages
Department of timportant: If ite
any injury or of 1 ☐ Burial 2 【**X**Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crem. 04/08/05 Alexandria, Virginia 22. Name and Address of Facility Greene Funeral Tome 21. Signature of Funeral Service Licensee Nelson E 814 Franklin St., Alexandria, VA 22314 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician a Respiratory Failure /Medical Due to (or as a consequence of) Examiner b. Dehydration Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). The law requires that the death certiticate be executed Exami c General Debility physician and the burial-tran Due to (or as a consequence of): Box 68760. Physician/Medical attending p IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month 4☐Pregnant at time of death 5 Other (specify) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ Decubitus Ulcer Sacral 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed?
1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? page 2 1 Yes 2 No Division of Vital To the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death Check onl one examiner? Other: ă P 1 ☐ Yes 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA 4XNursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 1 XNatural 2 Accident Injury death. 1 ☐ Yes 2 ☐ No investigation Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral [ 1st Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D45217 04/07/2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ${ t Adebowale Ajayi, MD}$ Greenbelt Rd., College Park, MD 20740

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

bleve & Spark

05-02568 RKD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item 26 per me 8842 4-22-05 vt
State of Maryland (Denartment of Health and Mental Hygiene

			FOI	ertificate of Death	giene Reg. No. 005   378
	Physicia		1. Decedent's Name (First, Middle, Last)  ROBERT MICHAEL JOHNSON	2. Date of De Month APRIL	3. Time of Death 12, 2005 12:20P. M
	/Medic Examin	er	4a. Facility Name (If not institution, give street and number) RT.301 SOUTH OF SHORT CUT ROAD	4b. City, Town, or Location of Death WALDORF	4c. County of Death PRINCE GEORGES.
	Funeral Director		5. Social Security Number  6. Sex  1. Age (In yrs. last birthda  2.14-72-3250  6. Sex  1. Age (In yrs. last birthda  2.14-72-3250  7. Age (In yrs. last birthda  2.14-72-3250	v) If Under 1 Year   If Under 24 Hrs.   8, Date of Bir	th 9. Birthplace (State or Foreign Country)
	D		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or		2, 1935 WASH., DC
	Maryla a-faho	tor	MARYLAND CHARLES WALD		1 ☐ Yes 2 ☒No
	with the	Dire	10e. Street and Number 1721 TEMI DRIVE	10f. Zip Code 20601	10g. Citizen of What Country? U . S . A .
9	nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland arthment of Health and Mental Hygiene. ortant: If item 27 is marked othar than "natural, or Itams 23a or 28a-f ahow injury or other traumatic evant, the Medical Examiner must be notified at age.	Funera		B. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  1 Yes 2 No Specify:	
-003	2 hours atural', cal Exa	ted by	3 Wildowed 4 Divorced Year or Dates:	sedent's Usual Occupation	WHITE  16b. Kind of Business/Industry
21215-0036	within 72 ene. than "n	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	ve kind of work done during most of working . DO NOT use retired)	TOWNSON A AGGOG
	be filed vital Hygie of other files	Be Co	1 2 RE	ALTOR  18. Mother's Name (First, Middle)	JOHNSON & ASSOC.  , Maiden Sumame)
Maryland	2 should be filed withir and Mental Hygiene. Is marked othar than aumatic evant, Ite M.	<b>To</b>	LESLIE CECIL JOHNSON  19a. Informant's Name/Relationship (Type, Print)  19b. Ma	SHIRLEY ANN iling Address (Street and Number or Rural Route Numb	
	and 2 sealth an n 27 ls i			1 TEMI DRIVE, WALDORF	
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If itam 27 Is any injury or other tra		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State	position (Name of Date rematory or other place)	20c. Location - City or Town, State
altin	permit. P. Departme Important any injury		21. Signature of Funeral Service Licensee MOO479	ALE PARK CREM. 4-14-() 22. Name and Address of Facility RAYMOND FUNERAL SERVI	5 RIVERDALE, MD
8	Dep any		23a. Part1. Enter the disease, or complications that caused the death. Do not	TA DIATA MARVIAND 2	0646
Į.	Physician -		shock, or heart failure. List only one cause on each line.	miles	Interval Between Onset and Death
	/Medical Examiner		resulting in death)  Due to (or as a c. nsequence of):	V	
60,	tificate be executed g physician and as the burial-transit	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Einer Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):		
68760,	a So	Medical	IF FEMALE:		
.O. Box	that the death cert ned by the attendin detached for use	Physician/N	23b. Was decedent pregnant  in the past 12 months?  23c. If yes, outcome of pregnancy  1 Live birth 2 Fetal death	B ⊟Ectopic pregnancy □ Other (specify)	23d. Date of delivery Month Day Year
Φ.	w requires that the been signed by th should be detache	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I. 23e. Did t	obacco use contribute to the cause of death? Yes 2∭No 3 ☐ Probably 4 ☐Unknown
al Records,	The law ate has b page 2 sl	Completed	· · · · · ·		
f Vital	Physician: Th this certificate al director, pag	To Be	25. Was case referred to medical examiner?  1   Yes 2   No  No Provided Hospital: 1 □ Inpatient 2 □ ER/Outpat	26. Place of Death (Check only of ther: 4 □ Nursing Home 5 □ Resi	one)  dence 6X1Other (Specify) at scene
on of			27. Manner of Death 1 Natural 5 Pending Month, Day Year) 1/2 Natural 1/2 Natur	of 28c. Injury at 28d. Describe Work?	how injury occurred
Division	r Attenter deal	Sertification;	Accident investigation   4   10   10   10   10   10   10   10	street, factory, office 28f. Location ( City or Ton	Street and Number or Rural Route Number or Rural Route Number or Rural Route Number of Rural Route Number (No. 1864). Wildows (No. 1864).
	To tha Hospital o within 24 hours af To the Funaral D completely filled in	edical C	29a. Certifier (Check only one)  1 ☐ Certifying Physicien: To the best of my knowledge, de 2  Medical Examiner: On the basis of examination and/or and manner stated	ath occurred at the time, date and place, and due to the	cause(s) and manner as stated.
	To tha within 2 To the comple	Med	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
			· Califold	OCME	APRIL 13, 2005
_			30. Name and address of person who completed cause of death (Item 23a) (Type 24BIULIAH AU		timore, Maryland 21201
	Sta Registr		31. Date filed (Month, Day, Year)  32. Registrar's Signature	3	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene UU 5 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Martha James 1145 2005 10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Peninsula Gioral Nedical Cente. Under 1 Year If Under 24 Hrs. Wiconico 8. Date of Birth (Month, Day, Year)
Dec. 29, 1938 7. Age (In yrs. last birthday, 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** Days 1 ☐ M 2 🗓 F Months Hours 66 Pakistan Director 095-78-4897 Usuel Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Item 27 is marked other than "natural", or items 23a or 28a-f shot other traumatic event, the Wedical Examiner must be notified at 1 XYes 2 No Director Maryland Dorchester Cambridge 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Pakistan 503 Muir Street, Apt. 102 21613 Funeral 12. Was Decedent Ever in U.S.
Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: þ South Asian 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within. Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than " College (1-4or 5+) Elementary/Secondary (0-12) Registered Nurse Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Joseph Shah Mariam (Maiden Surnam Unknown) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 175 N. Fayette Drive, Fayetteville, GA 30214 Zino James/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 X Removal from State injury or 4 □ Donation 5 □ Other (Specify) Bahar Colony Unknown Lahore, Pakistan 21. Signature of Femeral Service License zeller Funeral Home, P. O. Box 207 any ir 106 Main Street, East New Market, MD 21631 23a. Pard. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** preumona weeks /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit Due to (or as a consequence of): Box 68760, attending physician Physician/Medical as the l IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 0 in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No 1 ☐ Yes 2 ☐ No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 X No P Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: 1 Natural 2 Accident 5 Pending investigation death. 1 Tes 2 No Director: 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined after 4 Thomicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Hospital or Attending Physician: within 24 hours a To the Funeral D To the

> State Registrar

31. Date filed (Month, Day,

hartes

29b. Signature and title of certifier

R.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Silvia



JV

29c. License number

D3087

Regional medical

29d. Date signed (Month, Day, Year)

			For State Registrar	State of Maryland / Dep	partment of Health and ertificate of Death		iene <sub>99. No.</sub> 2005   3780	2
	Physici		Decedent's Name (First, Middle, Las     Kurt Kahn	t)		2. Date of Deat Month 04	h Day Year 05 2005 2:02 P M	<i>;</i>
	/Medic Examin		4a. Facility Name (If not institution, give	,	4b. City, Town, or Location of Dea		4c. County of Death	
	Funeral Director		Holy Cross Hospit 5. Social Security Number 6. Security Number 137–16–6218		Silver Spring  // If Under 1 Year If Under 24 Hr  Months Days Hours Mir			
	yland how		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or	Location		10d. Inside City Limits	_
	the Mar 28a-f si	rector	MD Montgomer	y Silver S	oring 10f. Zip Code	1	1 (XYes 2 □ No Og. Citizen of What Country?	
	h with	i Di	1131 University B1	.vd W. Apt-1605	20902		United States	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or Items 23e or 28e-f show may jury or other traumatic event, ite Medical Exercificat must be redifficated and once.	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces?  1 X Yes 2 □ No WW II If Yes, Give Year or Dates:	. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue 1 ☐ Yes 2 🎇 No Specify:	Specify Yes or No- orto Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White	
21215-0036	ithin 72 hou he. han "natura han "natura	Completed	15. Decedent's Ed (Specify only highest grade Elementary/Secondary (0-12)	de completed) (Giv	edent's Usual Occupation re kind of work done during most of w DO NOT use retired)	orking	16b. Kind of Business/Industry	_
22	Hygier Hygier ther th		12 17. Father's Name (First, Middle, Last)	Bute	cher	ame (First, Middle, M	Meat Products Maiden Sumame)	_
ylan	nould be d Mental I narked o natic eve	To Be	Moritz Kahn	Too Salah	Lina	Unknown		
Baltimore, Maryland	1 and 2 st Health and tam 27 is r		19a. Informant's Name/Relationship (7  Susan Kahn - Wife  20a. Method of Disposition	1131 20b. Place of Dis	position (Name of	W. Apt-160	20902 05 Silver Spring, MD 20c. Location - City or Town, State	19
<u>E</u>	Pages ment of ant: If it		1  ☐ Burial 2 ☐ Cremation 3 ☐  `4 ☐ Donation 5 ☐ Other (Specify	Removal from State	ematory or other place) ark Cemetery 04/	08/2005	Paramus, New Jersey	
Balt	permit. Departr Imports any inj		21. Signature of Funeral Service Licen:		22. Name and Address of Facility Lines-Rinaldi Fund L1800 New Hampshi	eral Home,	Inc. lver Spring, MD 20904	
	Pnysician /Medical Examiner	er	Immediate Cause (Final disease or condition resulting in death)	a. Myocardial Infare  Due to (or as a consequence of):  Coronary Thrombos  Due to (or as a consequence of):  Due to (or as a consequence of):	ction	ac or respiratory arre	est, Approximate Interval Between Onset and Death	_
8760,	icate be executed physician and s the burial-transit	dicai Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Coronary Ischemic Due to (or as a consequence of): d. Arteriosclerosis	Disease			_
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ecords, P	w requires that been signed b should be deta	ed by Pł		ontributing to death but not resulting in the ve Pulmonary Diseas	, ,		oacco use contribute to the cause of death? os 2 ፟XNo 3 ☐ Probably 4 ☐Unknown	
Œ	The law ate has b page 2 sl	Completed by				24a. Was an autops perform	v prior to completion of cause of	
Vital	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:	Other	eath (Check only on		
Division of	ing After une	ation: To	1 Yes 2 X No  27. Manner of Death  1 X Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)  28b. Time Injury	of 28c. Injury at		nnce 6 Other (Specify) w injury occurred	
Divis	tal or Attand rs after death al Director: /	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (St City or Town	reet and Number or Rural Route Number, o, State)	
	ne Hospital of 24 hours at 18 Funeral Distriction of 18 Funeral Distriction of 18 Filled in 18 F	edical		ysicien: To the best of my knowledge, de nîner: On the basis of examination and/or and manner stated.				
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,	10		30. Name and address of person who	completed cause of death (Item 23a) (Tyd	D0009215		04/06/2005	_
	Sta	te	Lawrence Marcus,	MD 10313 Georgia Av 2005 32. Figistrar's Signature	re Suite-207 Silve	er Spring,	MD 20902	_
	Regist		AFK U /	Alsen St. 1	grave			

			1 - For State Registrar	State of Ma	arylan				lealth an Death		F	leg. No.	200	5 137	184
	Physici	an	Decedent's Name (First, Middle, La     MARGIE	C.	ZΛ	OWLES					Date of Dea Month		,2005	3. Time of De	7
	/Media	al	4a. Facility Name (If not institution, giv		VI	OMPES		v. Town, o	r Location of D		IAICII		County of Dea		
	Examir	er	HOLY CROSS H					-	SPRI			1	ONTGO		
	Funeral Director		5. Social Security Number 6. S			last birthday) 32 Yrs.	If Und Month	er 1 Year s Days		Hrs. 8. Min. Ma	Date of Birth (Month, Day 11.21	Year)	23 Mai	rthplace (State or F country) Cyland	oreign
	/land		10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d. Inside City I	Limits
	Man B-f sh	tor	DC		Wa	shing	tor	1						1 <b>Z</b> Yes 2	□No
	or 28	)ire	10e. Street and Number			<u> </u>	10f. 2	Zip Code					izen of What C		
	ath w	la	211 16th St,					200					U.S.A		
21215-0036	be filed within 72 hours after death with the Maryland stal Hyglene.  ad other than "natural", or Items 23a or 28s-f show event, the Modical Examinational terministic at	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 ➡ Widowed 4 □ Divorced	12. Was Decedent 6 Armed Forces? 1 Tyes 2 The lif Yes, Give Year or Dates:	ever in U.	1		edent of Hoecify Cuba 2 A No	lispanic Origin an, Mexican, P Specify:	? (Specify uerto Rica	/Yes or No- an, etc.)		14. Race - Am Black, Wh Specify: B	ite, etc.	
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121	within	μ	Elementary/Secondary (0-12)	College (1-4or 5	+)		oo <i>not</i> iest		1)				Home		
5	filed v Hygie ther t	e Co	17. Father's Name (First, Middle, Last	Lyr		DOI	iesi	.1.C	18. Mother's	Name (Fi	irst. Middle				
Maryland	0 m 0 %	To Be	Edward H. Pr	ather		10b Mailie	o Addre	on (Street	Ev	a Ja	ackso	n	r Town, State,	Tin On do l	
Ma	th an 27 is in traus		Ward Knowles -			211	16t	h Si	r, NE	#4 1	Vashi	ngt	on, D	20002	
Baltimore,	permit. Pages 1 and 2 should b Department of Health and Ments Important: If item 27 is marked any injury or other traumatic ence.		20a. Method of Disposition 1  → Burial 2 □ Cremation 3 □		0	Place of Dispo	natory o	r other plac	ce) 4/	Date			ither	r Town, State sburg, MI	D
틀	artme ortani injury		'4 □Donation 5 □ Other (Special 21. Signature of Funeral Service Lie)		DIC	1) 22	. Name	and Addre	ss of Facility	Snov	vden	Fun	eral	Home P.A	Α.
Ba	Depar Impor any ir		1 copy	shoude	1 /	1 2	246	N. V	√ashin	gtor	n St	Roc	kvill	e, MD 20	3850
	Physician /Medical		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)		ONA]	RY EMI			ig, such as car	rdiac or re	spiratory arr	est,		Approximate Interval Betwee Onset and Dea HOURS	∍n µth
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	ires that I signed by d be deta	by	Part II. Other significant conditions of	contributing to death bu	ut not res	ulting in the ur	nderlying	cause giv	en in Part I.					o the cause of deat	
Sor	w require been sig should b	lete								-	24a. Was a	ın.	24h Wara a	utoney findings ava	ulable
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Division	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	Certification:	3 Suicide 6 Could not be determined	OB Place of Inju	ıry - At ho c. (Specif	ome, farm, stri	eet, facto	ory, office		28f.	Location (Si City or Town			ural Route Number	,
	To the Hospital or within 24 hours afte To the Funeral Dirt completely filled in I	edical C	29a. Certifier 1 Certifying Pl (Check only one) 2 Medical Exam	nysician: To the best of miner: On the basis of and manner sta	examina	wledge, death tion and/or inv	occurre estigation	ed at the tin	ne, date and pi pinion, death o	lace, and occurred a	due to the cat the time, d	ause(s) late and	and manner a place, and du	s stated. e to the cause(s)	
	To th within To th comp	Me	29b. Signature and title of certifier					9c. Licens			2	9d. Dat	e signed (Mon	th, Day, Year)	
			A.Na	was.			i	050	187			4.	-1-05	5 ′	
	10		30 Name and address of person who	completed cause of de	eath (Item	n 23a) (Type,	Daim #\				5				
			AHMED NAL	UAZ 10	) 130	0×838	319	9	AITHE	FRZ	BUR	9	mp o	-0003	
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Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible. Amend 1 tem 23e, 24a per doc 8845 7-21-05 vt State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** H.Livel han les : 56 8 2005 10 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Salsbury
If Under 1 Year If Under 24 Hrs. WICOMICE New Ave OFK Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6 Sex 8. Date of Birth (Month, Day, Year) **Funeral** Hours Min 215445970 1 3 M 2 F Months Days 9 5 Yrs. MT. Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10h County 10c. City, Town or Location 10a State 10d. Inside City Limits ehow Pages 1 and 2 should be filled within 72 hours after death with the Maryla nent of Health and Mental Hygleine.

The should shall be shown and the shown and the state of the shown and the shown and the shown and the shown and the should like the shown after the should like the should be notified at any or other treumatic event. 1 Yes 2 No Director MD Wi wmico Salisbu 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2180 104 Nº EW Ave onk USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes Z No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) ·Ordinator 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumar Be MARIE HAALES -17EFA ဥ OTHERLINE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 104 WIFE EW ORK 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place) 1 ⊠Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Importent: If any injury or once. 4 □ Donation 5 □ Other (Specify) DATING HILL 05 EW EBROK 21. Signatura Fun ral Service Licensee 22. Name and Address of Facility SMITH FIH BENNIE 917WISABELLA ST. SALISBURY Ma 21801 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician Prostate /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisease or hijary that initiated events resulting in death) Last Due to (or as a consequence of): Examiner sician and s burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): MIC # 1240 of Vital Records, P.O. Box 68760, by Physician/Medical the as IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery ned by the attend detached for us 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed' certificate 2 No 1 Yes 2□ No 1 ☐ Yes To the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Seriesidence 6 Other (Specify) 1 ☐ Yes 2 ☑ No P 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death Injury at Work? 28d. Describe how injury occurred Certification: After Division 1 Natural 5 Pending investigation М 1 ☐ Yes 2 ☐ No death. 2 Accident the **Director**: 6 ☐ Could not be 3 🔲 Suicide Płace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by efter 4 - Homicide within 24 hours e To the Funerel C 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number HOS 5619 4, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 218 Nout hose Salisb 31. Date filed (Month, Day, Year) APR 1 2 2005 32. Signature State Registrar

njury or other treumatic event, the Madical Examiner outst be notified at the matter of the sector and the sector To Be Completed by Funeral Director	Usual Residence of Decedent  10a. State	WERY  Street and number)  AL  X	City, Town or Lo STEVENS V  1 (16a. Dece (Give life)  CONT		If Under 24 H Hours Mi Hispanic Origin? an, Mexican, Pu Specify: bation during most of v	S. B. Date of Bi (Month, D JAN . 3	Day 4, 200 4c. County TALE  rth ay, Year) 1945  10g. Citizen of USA	y of Death BOT  9. Birthpla Countr MD  100  What Countr ce - American ck, White, et	n Indian, tc. LTE	P <sup>M</sup> Foreign
ther treumstic event, the Madical Examiner has be notified at the desired at the manufacture of the manufact	4a. Facility Name (If not institution, give s  MEMORIAL HOSPITA  5. Social Security Number  219-42-8557  Usual Residence of Decedent  10a. State  10b. County  MD  QUEEN AN  10e. Street and Number  608 LOVE POINT RO  11. Marital Status  1 Never Married  3 Widowed 4 Divorced  15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)  12.  17. Father's Name (First, Middle, Last)  SAMUEL WHITE LOWE  19a. Informant's Name/Relationship (Ty, LORETTA LOUISE LO)  20a. Method of Disposition  1 X Burial 2 Cremation 3 Re	AL  X  AL  X  AN  AN  AN  AN  AN  AN  AN  AN  AN	O Yrs.  City, Town or Lo  STEVENS V  1 (1.6.)  1 (1.6.)  1 (1.6.)  1 (1.6.)  CONT	EASTON  If Under 1 Year  Months Days  Decation  TLLE  10f. Zip Code  21666  Was Decedent of H If Yes, specify Cube I U Yes 2 X No  dent's Usual Occup kind of work done of NOT use retired	If Under 24 H Hours Mi Hispanic Origin? an, Mexican, Pu Specify: bation during most of v	APRIL  S. B. Date of Bi (Month, D  JAN . 3  (Specify Yes or N  arto Rican, etc.)	4, 200 4c. County TALE  That And And And And And And And And And And	y of Death  OT  9. Birthpla Countr  MD  100  What Countr  ce - American  ack, White, et	ace (State or I y)  d. Inside City  1 □ Yes 2  ry?  n Indian, tc.	Foreign Limits
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	19a. Informant's Name/Relationship (Ty)  LORETTA LOUISE LO  20a. Method of Disposition  1 X Burial 2 Cremation 3 R	vpe, Print)				ame (First, Middle		me)		
	LORETTA LOUISE LO	_	10h Maili	ng Address (Street		NE CLARK		State Zin C	Code	
	20a. Method of Disposition 1   ■ Burial 2 □ Cremation 3 □ R	MENT/MILL	1	LOVE POIN					666	
a l		201	b. Place of Dispo			Date	20c. Location			
oi I		Removal from State		LLE CEME	1	08/2005	STEVENS	SVILLE	, MD	
SUC	21. Signature Fineral Service License	el le	, F	2. Name and Addre ELLOWS, E 06 SHAMRO	IELFENBE	IN & NEW	NAM FUNI R. MD 2	ERAL HO 21619	OME, P	.А.
clan/Medical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a const.  Due to (or as a const.  Due to (or as a const.  Due to (or as a const.)	sequence of):							
Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time ( 9 ☐ Unknown	etal death 3[	⊒Ectopic pregnancy ⊒ Other (specify) _	у			ate of delivery onth C	y Day Ye	ar
b	Part II. Other significant conditions cor	ntributing to death but not	resulting in the u	underlying cause giv	en in Part I.		tobacco use cor	ntribute to the	0.4	ath? known
Completed							s an 24b. opsy ormed? 2 \square No	prior to comp death?	sy findings av	ariable se of
Be (	25. Was case referred to medical examiner?	Unaniani.	0+00+=	0,4		eath (Check only	one)	1		
tion: To Be Com	1 Yes 2 No  27. Manner of Death  Whatural 5 Pending 2 Accident investigation	Hospital: 1 Inpatient 28a. Date of Injury (Month, Day Year	28b. Time of Injury	of 28c. Injur Wor	4   Nursing	Home 5 Res 28d. Describe	idence 6 🗆 Ot how injury occu	1 , ,,		
Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - A building, etc. (Sp		reet, factory, office		28f. Location City or To	(Street and Num own, State)	ber or Rural	Route Numbe	r,
Medical Certifica	29a. Certifier 1 Certifying Physical Control Check only one)	rsician: To the best of my iner: On the basis of exam and manner stated.	knowledge, deal mination and/or in	th occurred at the time time time the time time the time	me, date and pla opinion, death o	ce, and due to the curred at the time	e cause(s) and m	anner as sta , and due to t	ited. the cause(s)	
Me	29b. Signature and title of certifier	- 1		29c. Licens			29d. Date sign			
	Therebull	Ving me	0	00	CME		APRIL	5, 2	2005	
-	30. Name and address of person who co	ompleted cause of death (	(Item 23a) (Type	Print) 111 Pe	enn Stre	et Balt	imore, I	Maryla	nd 212	0.1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month

4b. City, Town, or Location of Death

Wheaton

April

1:40

10d. Inside City Limits 1 Yes 2 No

Black

2005

4c. County of Death

Montgomery

av

2000

Approximate Interval Between Onset and Death

Year

Day

2 No

**Physician** /Medical Examiner For State Registrar

George

F.

Manor Care Nursing Facility

4a. Facility Name (If not institution, give street and number)

Lomax

**Funeral** Director

Examiner use as the burial-transit Box 68760, P.O. detached

Hours Min. 1 0 2 8 2 9 1 9 2 0 Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6. Sex Days 1**X** M 2□ F Months Unknown 577-20-4018 Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City, Town or Location 27 is markad other than "natural", or itams 23a or 28a-f show traumatic event, the Medical Examiner must be notified at MD Director Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1110 Fidler Lane #1500 20910 USA permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. In mortant: If Item 27 is marked other than "natural; or Items 23e any injury or other traumatic event. The Medical Feature 200.00. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Unknown Unknown 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 Unknown Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cheryl Johnson/Grandaughter 5107 Woodland Blvd., Oxon Hill, MD 20745 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 4-13-2005 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Quantico Nat'l Cem Triangle, VA <sup>1</sup> 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Taylor's Funeral Home 21. Signatur 1 Funer Service Licensee 1722 N. Capitol St. NW, Washington DC 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** a Arrythmia disease or condition resulting in death) /Medical Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by of Vital Records. should be Hypertension 1 Yes 2 No 3 Probably 4 Kinknown Diabetes Mellitus 24a. Was an autopsy performed?
1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? page 2 Stroke 1 Yes or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Injury Division 1 Natural 5 Pending 1 Yes 2 No investigation М hours after death 2 Accident the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by t determined 4 Homicide hilled within 24 hours To the Funarai 29a. Certifier 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0 D58962 April7, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2309 Shorefield Rd., Wheaton, MD 20902 Patel Shashank 31. Date filed (Month, Day, Year) 2. Registrar's Signature State APR 1 1 2005

DHMH 17 Rev 1/2001

Registrar

State of N	warytand / Department of Health and W	lental Hygiene	
or.	Certificate of Death	Reg. No. 2005	
Name (First, Middle, Last)		2. Date of Death	3. Tir

Physician
/Medical
Examiner

Director

Completed by Funeral

**Funeral** Director

the Maryland itam 27 is marked other than "neturel", or Items 23a or 28e-f show other traumatic avant, the Medical Examinar must be notified at

2 should be filed within 72 hours after on and Mental Hygiene. Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 sh Department of Health and Important: If itam 27 is rr any injury or othar traum once.

Physician /Medical Examiner

certificate be executed

Division of Vital Records, P.O. Box 68760

Hospital or Attending Physicien:

within 2 To the

Examiner the attending physician and hed for use as the burial-transit Physician/Medical ð Completed Be ٩ this Certification: After

1. Decedent's April 17, 2005 Ernest Moore 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Allegany Memorial Hospital Cumberland If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day, Year) May 5, 1949 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Months Days Hours Min. 1√2 M 2 🗆 F 217-52-1355 Yrs. 55 Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County Allegany MD Flintstone 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 26604 National Pike NE 21530 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: white 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Ed's Mobile Home Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Emmett Kyle Moore Betty L. (Bell) Moore 19a. Informant's Name/Relationship (Type, Print)
Priscilla Moore 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 26604 National Pike NE Flintstone MD 21530 wife 20b. Place of Disposition (Name of cometery, crematory or other place)
Scarpelli Funeral Home, PA 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Date 20c. Location - City or Town, State 4/21/2005 Cresaptown 4 □ Donation 5 □ Other (Specify) 21. Signatura of Funeral Service Licenses 22. Nam Scarbellis Pune Home, PA 108 Virginia Avenue. Cumberland, MD 21502 23a. Left1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Multiple Inhunes Due to (or as a consequence of Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 

Yes 2 □ No 24a. Was an autopsy performed? 1 X Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

1 XYes 2 ☐ No 27. Manner of Death 1 Natural 2 🗷 Accident 3 🗌 Suicide

4 \ Homicide

(Check only

29a, Certifier

Medical

5 Pending investigation 6 Could not be determined

28a. Date of Injury (Month, Day Year) 4-17-05

yard it

Treenberg MD

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of Injury 12:20 PM

1 ☐ Yes 2 1 No

29c. License number

28d. Describe how injury occurred tree feil on subject

28f. Location (Street and Number or Rural Route Number, City or Town, State) 26604 National PIENE Flintstane, MD 21530 1 Certifying Physicien: The best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

lasha

OCME

29d. Date signed (Month, Day, Year) April 18, 2005

ne of Death

Рм

2:07

10d. Inside City Limits

1 ☐ Yes 2/☐ No

MD

Approximate Interval Between Onset and Death

Day

Year

Wid

30. Name and address of person who completed cause of death-(ftem 23a) (Type, Print) Zareenbera

111 Penn Street Baltimore, Maryland 21201

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month P) 2 2005

home

			1 - For State Registrar	State of M		d / Depa		t of H	ealth a					13720
			Decedent's Name (First, Middle, Last			001	imoati		- Cuiri		2. Date of Dea		w U U	3. Time of Death
	Physici	an	Bal		ajan						April 3	Day	Year	0405 M
	/Medio		4a. Facility Name (If not institution, give				4b. City.	Town, or	Location of	of Death	Whiii .		inty of Deeth	
1	Examir	ıer	2990 Summit Drive		,				svill				Frede	
	Funeral		5. Social Security Number 6. Se		ge (In yrs. la	ast birthday)	If Under		If Under:		8. Date of Birth	1		
	Funeral Director			M 2□F	70	Yrs.	Months	Days	Hours	Min.	8. Date of Birth (Month, Day Feb. 20	), Year)	35 Îr	place (State or Foreign intry) 1012
	land		10a. State 10b. County		10c. City	, Town or Lo	cation							10d. Inside City Limits
	e Mary Ba-f sho	Director		erick			Ija	msvi	lle					1 ☐ Yes 2 🙀 No
	72 hours after death with the Maryland natural', or Itams 23a or 28a-f show areal Exeminent must be notified at	ai Dire	10e. Street and Number 2990 Summit Drive				10f. Zip	Code	2	21754		-	of What Cou U.S.A.	•
	dea	Funerai	11. Marital Status	12. Was Decedent Armed Forces		3. 13.	Was Deced	lent of His	spanic Orig	gin? (Spe	ecify Yes or No- Rican, etc.)	14. [	Race - Ameri Black, White	
9	after or Its	F	1 Never Married 2 Married	1 Tes 27			1 🗆 Yes		Specify:	, 1 00110	riioari, oto.,	l l	ecity: Inc	
93	ral',	l by	3 Widowed 4 Divorced	Year or Dates:				2 (2 (40	opeony.			306	icny. IIIC	izari
5-0	72 hours "natural", o cal Ex-	Completed	15. Decedent's Edu (Specify only highest grad	cation cation		16a. Deced	dent's Usua kind of wo DO NOT us	il Occupa rk done d	ition Ju <i>ring m</i> osi	t of worki	na	16b. Kind o	f Business/Ir	ndustry
21	⊆ *_3	ldu	Elementary/Secondary (0-12)	College (1-4or	5+)									
2		Con		5+		Gener	al Ma				visor			nment
pq	m - 0 %	Be	17. Father's Name (First, Middle, Last)						18. Mothe		(First, Middle,	Maiden Sun	name)	
la	should be ind Mental marked o	J.	Chuni Mahajan						Indr	a N	1ahajan			
Maryland 21215-0036	and and ls m		19a. Informant's Name/Relationship (7) Ellen Dee Mahajan				_	,			amsville			1
ē,	s 1 and 2 if Health itam 27 othar tra		20a. Method of Disposition		20b. Pl	ace of Dispo	sition (Nar	ne of			ate		on - City or T	
D	ages ant of t: If i		1 Burial 2\ Cremation 3 F	lemoval from State	Smith	nmerery, cren ISburg	crem	ator	y Ar	ril	20, 200	)5 Sm	ithsbu	ırg, Marylan
Baltimore,	permit. Pages Department of H Important: If its eny injury or of	1	21. Signation of Funeral Service Licens		2					v	,			,
Ba	Deport Perry		1/1 / 1 / 1		MOC	0021 2	Keen	ey a	nd Ba	ísfor	d Funer	al Ho	me	
			23a. Part1. Enter the disease, or compleshock, or heart failure. List only o	ications that cause	d the death	Do not ent	106	East	Chur	cardiac o	street,	Frede	rick,	MD 21701 Approximate
и			shock, or heart failure. List only o	ne cause on each	line.	. Do not one	or the mod	o or aying	g, 300m as	our dido c	i respiratory arr	651,		Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	3		iple M								6 months
	/Medical Examiner		resulting in death)	Due to (or as	s a consequ	ence of):								
	LAGITITIO	_	Sequentially list conditions,	o										
	p ii	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	з а сольеци	ence ot).								
٧	te be executed ysician and te burial-transit	ше	that initiated events resulting in death) Last	o										
760,	e ex slan s	Ü	rooming in dominy addition	Due to (or as	s a consequ	ence or):								
376	e y	licai		d										
89	death certifical e attending phy d for use as th	Med	IF FEMALE:											
Вох	th ce tendi	Physician/M	23b. Was decedent pregnant	3c. If yes, outcome 1 ☐ Live birth			Ectopic pr	egnancy					Date of deliv Month	rery Day Year
	0 0 0	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregnant a 9□Unknown	at time of de	ath 5	Other (sp	ecity)					MOITH	Day
P.0	at the de by the	h	9 🗆 Unknown								T			
	The law requires that the ste has been signed by the bage 2 should be detache	by	Part II. Other significant conditions co		but not resu	iting in the u	nderlying c	ause give	in in Part I.			/		the cause of death?
D	v require been si should I		Renal failu	re							1 🗆 Y	es 2 No	o 3 ☐ Prol	bably 4 □Unknown
Records,	aw re s be	Completed									24a. Was a	in 24	b. Were auto	opsy findings available ompletion of cause of
Ä	The fav	E									autop: perfor	med? 2 No	death?	21 LHO
Vital		0	25. Was case referred to medical				-		26. Place	of Death	(Check only or			
5	Physician: this certific ral director,	0	avaminar?	lospital:	ient 2 🗆 E	ER/Outpatien	it 3 DC	Othe			me 5 Mesid		Other (Speci	fv)
ō		<u>-</u>	27. Manner of Death	28a. Date of Inj (Month, Da		28b. Time of		8c. Injury Work	at		28d. Describe h			-97
Division	Attending In death.  ector: After by the funer	tio	1 Natural 5 Pending 2 Accident investigation	(Month, Da	ay rear)	Injury	М		.≀ /es 2 🔲 I	No				
/is	Attendi	fice	3 Suicide 6 Could not be	28e. Place of Ir	ijury - At hor	me, farm, str	eet, factory	, office					mber or Run	al Route Number.
Ö	- 9 -	Certification;	4 Homicide	building, e	itc. (Specify	)					City or Tow	n, State)		//
	To the Hospital o within 24 hours at To the Funaral D completely filled in		29a. Certifier 1 Certifying Phy	sician: To the bes	t of my knov	vledge, death	n occurred	at the tim	e, date an	d place,	and due to the o	ause(s) and	manner as s	stated.
	e Ho 24 t Full etely	Medical	(Check only 2 Medical Exami		of examinati									
	To the within 2 To the complet	Me	29b. Signature and title of certifier		1		290	. License			2	29d. Date sig	ned (Month,	Day, Year)
	->-0		Poseph M	. Hagge	rly	me		D3:	2407			April	19, 2	005
	1		30. Name and address of person who ca											
	5		Joseph M. Hager					anta	o Dari	770	Suita 2	-α n	olari 1	1. MD 2005
	Sta	10	31. Date filed (Month, Day, Year)		trar's Signat		ar U	FIICEI	- DLT	ve,	parte 3	oo, Ka	JCKVII.	TE, MD 2085/
	Ste Regist				Lo	Acart.								
			APR 2 2 2005	FIS ACRES O	A.F.	The orange								

John Mark McKenzie, Jr. Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 05-02715 State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav **Physician** McKenzie Mark 2005 4c. County of Death April 18 a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Allegany County Route 36, North of Midland | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Aug 1, 1983 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** Months 1 M 2 □ F MD Yrs. Director 213-06-1832 Usual Residence of Decedent the Maryland 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other than "natural", or Itema 23a or 28a-f show other traumatic event, the Madical Examination and be notified at MD Allegany Cumberland X☐Yes 2☐No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21502 USA 303 Grand Avenue by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decadent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 2 should be filed within 72 hours after a and Mental Hygiene. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: X□ Never Married 2□ Married 1 ☐ Yes Ž☐ No Specify white 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) **Felemarketer** J.A.K. 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Mark McKenzie, Sr. Connie Lamp 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
203 Grand Avenue Cumberland MD 21502 19a. Informant's Name/Relationship (Type, Print) is 1 and 2 soft Health an mother Connie Lamp 20b. Place of Disposition (Name of cemetery, crematory or other place)
Sunset Memorial Park 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of Hi
Important: If Iter
any injury or oth 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4/22/2005 MD Cumberland ^ 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Home, PA 21. Signature of Funeral Service Licenses 108 Virginia Avenue: Cumberland, MD 21502 23a. Part / Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician Multiple Nuries disease or condition resulting in death) /Medical Due to (or as a consequence) f) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter of 37 mg Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the attending physician and hed for use as the burial-transit certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed ain: Yes 2 No 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 0 1 X Yes 2 □ No  $4 \square$  Nursing Home  $5 \square$  Residence  $6 \nearrow$  Other (Specify) At scene this 28a. Date of Injury
(Month, Day Year) 27. Manner of Death 28b. Time of Injury 21d. Describe how injury occurred driver of motor vehicle involved e Hospital or Attending 124 hours after death. Natural 5 Pending investigation

6 Could not be determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the causers) and manner at stated. 2 Accident 3 Suicide 4 Homicide Midland 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the To the To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifi OCME April 19, 2005 30. Name and address of person who ipleted cause of death (Item 23a) (Type, Print) 3 0111 Penn Street Baltimore, Maryland 21201

State

Registrar

filed (Month, Day, Year) APR 2 2 2005

Cost !

32. Registrar's Signature

	•		Please Type or Print in Black Inc		•	•
			1- State of Maryland / Depart 1- State of Maryland / Depart 1- Registrate #29dpert 1- Registrate Registrate #29dpert 1- Registrate Registrate Registrate Registrate Registrate Registra	tificate of Death		2005 12701
			1. Decedent's Name (First, Middle, Last)	incate of Death	2. Date of Death	3. Time of Death
	Physici		Cynthia Thomas Martin		April 2.	2005 Year 6:05am
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
			Suburban Hospital	Bethesda		Montgomery
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year   If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Y	(ear) 9. Birthplace (State or Foreign Country)
	Director		Usual Residence of Decedent		Nov. 1,	1954 Alabama
	land ow		10a. State 10b. County 10c. City, Town or Lo	cation		10d. Inside City Limits
	Mary	ţō	Maryland Montgomery Germantown	n .		1 ☐ Yes 2 📉 No
	n the	Director	10e. Sireet and Number	10f. Zip Code	10g	3. Citizen of What Country?
	23e c	alD	13508 Jamison Place	20874	U	nited States
	tems	Funeral	Armed Forces?	Was Decedent of Hispanic Origin? (Sp f Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, While, etc.
36	s afte	by Fi	1 ☐ Never Married 21X Married 1 ☐ Yes 2 X2 No If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates:	1 ☐ Yes 2 ☑ No Specify:		Specify: White
21215-0036	72 hours after death with the Maryland neturel', or Items 23e or 28e-f show lical Exercipal contiled at		15, Decedenl's Education 16a, Deced	dent's Usual Occupation	16	Sb. Kind of Business/Industry
215	nin 72 nn "ne Me Ill	plet	(Specify only highest grade completed) (Give	kind of work done during most of worl DO NOT use retired)	king	<b>,</b>
21	filed within Hygiene.	Completed		tionist		Nursing Home
	be filed tal Hygi d other event, I	Be (	17. Father's Name (First, Middle, Last)	18. Mother's Nam	ne (First, Middle, Ma	iden Sumame)
yla	should be and Mental s marked o umetic eve	ြ	Unknown Unknown	Agnes K		
Maryland	12 sho h and 7 Is mu treum	1 8		ng Address (Street and Number or Ru		
	is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. Item 27 is marked other then "neturel", or items 23e or 28e-1 show citem 27 is marked other then "neturel", or items 23e or 28e-1 show citem treumetic event, the Medical Execution in and the notified at		20a Method of Disposition 20b. Place of Dispo	Jamison Place, G		, MD 208/4 lc. Location - City or Town, State
JOI.	ages ant of tr: If it		1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State cemetery, crem	natory or other place)		
altimore,	ten the sign		21. Signature of Funeral Service Licensee	. Name and Address of Facility De	Vol Funer	Alexandria, Virginia cal Home
ä	Depar Impo eny ir		Medeal Marchen 10	East Deer Park I Lithersburg, MD 20	rive 1877	
	Physician /Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause of each line.  Immediale Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence of):	0 0 -	or respiratory arrest	t, Approximate Interval Between Onset and Death
		mlner	Sequentially list conditions, fary, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events			
68760,	ficate be executed physician and s the burial-transit	dical Examin	resulting in death) Last  Due to (or as a consequence of):  d.			
O. Box	The law requires that the death certificate be ite has been signed by the attending physicii page 2 should be detached for use as the bu	Physician/Medical		Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
٠ <u>.</u>	res that igned b	by Pl	Part II. Other significant conditions contributing to death but not resulting in the un	nderlying cause given in Part I.	23e. Did toba	cco use contribute to the cause of death?
rds	w require been sig should b	ed b	MULTIPLE SCLEROSIS		1 ☐ Yes	2 No 3 Probably 4 Unknown
Il Records,	10	Completed			24a. Was an autopsy performe	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
Vital	ding Physiclen: h. After this certification funeral director,	Be	25. Was case referred to medical examiner?  Hospital:	Othor	th (Check only one)	
of	Phy this	. To	1 ✓ Yes 2 ☐ No Representation 1 ☐ Inpatient 2 ☐ ER/Outpatier 27. Manner of Death 28a. Date of Injury 28b. Time of		ome 5 TResidence 28d. Describe how	ce 6 Other (Specify)
OU	ding After fune	tlon	1 Natural 5 Pending (Month, Day Year) Injury	f 28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	200. 2030/100 /104	mjury occurred
Division	r Attending er death. rector: After i by the fune	Certification:	2 Accident  3 Suicide 4 Homicide  1 Homicide  1 Investigation  2 Se. Place of Injury - At home, farm, str building, etc. (Specify)		28f. Location (Stree City or Town,	et and Number or Rural Route Number, State)
D	ipitel o		29a. Certifier 1X Certifying Physician: To the best of my knowledge, deat	n occurred at the time, date and place	and due to the caus	se(s) and manner as stated
	To the Hospitel or Attent within 24 hours after dealt To the Funerel Director: completely filled in by the	Medical	(Check only 2 Medical Examiner: On the basis of examination and/or in and manner stated.	vestigation, in my opinion, death occu	rred at the time, date	a and place, and due to the cause(s)
	With To 1	Σ	29b. Signature and title of certifier	29c. License number	290	I. Date signed (Month, Day, Year) April 04, 2005
, a	5		~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~	1) cc 18	684 H	KIL 04,5004
			DINESH PATEL, M.D. 6(2)	MONTROSE R	o Rocu	WILLE KID 20852
	Sta Regist	ate rar	31. Date filed (Momit - Day, Year) 7 2005 32. Argistrar's Signature	Sold .	,	7

State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Day 2005 April 8, **Physician** Year Lillian Colleen Neal 10:10 A.M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Southern Maryland Hospital Clinton Prince George's If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7/11/22 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 🛛 F 82 Yrs. 228-16-7502 S.Boston, Va Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits ir than "natural", or Items 23a or 28a-f show The Medical Examinar must be notified at Md. XXYes 2 □ No Prince George's Temple Hills Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 3136 Brinkley Rd. # 201 20748 permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or Items 23a any injury or other traumatic evant. It a Ne Jical Examinating once. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 225 No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes → No Specify: Black þ 3X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 11th Elevator Operator U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Thomas Moore Lila Palmer 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara N. Brooks/Daughter 12907 Asbury Dr., Ft. Washington, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans Cem. 4/15/05 Cheltenham, Md. 22. Name and Address of Facility
H.S. Washington & Sons Co., Inc.
4925 Burroughs Ave., N.E., Washington, D.C. 20019 21. Signature of Funeral Service Lîcensee ance JANOV 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Congestive heart failure End stare Co Due to (or as a convequence of): Physician UNKnown disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter out rying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown signed t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Nonknown been signature Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has b irector, page 2 s autopsy performed? 2 No Yes To the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 10 this After this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Matural 1 ☐ Yes 2 ☐ No death. Diractor: / 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - Al home, farm, street, factory, office building, etc. (Specify) determined 4 Momicide within 24 hours a To the Funeral I 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month. Day, Year) 29b. Signature and title of certifier Ranto Frahe M. D. 043446 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9801 Georgia Are Suit 3-41 Silversp FARAHIFAR 31. Date filed (Month, Day, Year) . Registrar's Signature State APR 1 1 2005 Registrar

			1- State of Maryland / Dep	partment of Health and Mertificate of Death		giene 005	13793
	Physici		1. Decedent's Name (First, Middle, Last) Pauline Elizabeth Norwood		2. Date of Dea		3. Time of Death 10:40 PMM
	/Medio Examin		4a. Facility Name (If not institution, give street and number) College View Center	4b. City, Town, or Location of Death Frederick		4c. County of De Freder	rick -
	Funeral Director		5. Social Security Number 6. Sex 1 M 2 TF 88 Yrs.	If Under 1 Year   If Under 24 Hrs.   Months   Days   Hours   Min.	8. Date of Birt (Month, Day Dec. 2		irthplace (State or Foreign Country) Taryland
	f show	ō	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or L  Maryland Frederick Freder				10d. Inside City Limits 1 X Yes 2 □ No
	or 28a-	Director	10e. Street and Number	10f. Zip Code		10g. Citizen of What	Country?
	leath w	Funerai	700 Toll House Avenue  11. Marital Status 12. Was Decedent Ever in U.S. 13.	21701 Was Decedent of Hispanic Origin? (Spe	ecify Yes or No-	U.S.A.	nerican Indian,
036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-1 show an amaked other than "natural", or items 23a or 28a-1 show armstic evant, Ite McGrall Extra free in a the motified at	þ	Armed Forces?  1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☒ No Specify:	Rican, etc.)	Black, Wh	nite, etc.
Maryland 21215-0036	thin 72 ho e. an "natur Modeal	Completed	(Specify only highest grade completed) (Giv.	edent's Usual Occupation e kind of work done during most of worki DO NOT use retired)	ng	16b. Kind of Busines	•
2	Hygien Hygien thar th nt, the		11 ASS	embly Line Worker  18. Mother's Name	(First Middle	Manufactu	ring
yland	Mental I Mental I Brked of atic eva	To Be	George W. Droneburg		. Etzle		
2	and 2 sho ealth and n 27 Is m		19a. Informant's Name/Relationship (Type, Print)  Mrs. Katherine Y. Campbell, sister	ling Address (Street and Number or Rura 1507 West Seventh			, Zip Code) MD 21702
altimore,	Pages 1 ar nent of Hea ant: If itam: ury or otha		20a. Method of Disposition  20b. Place of Disposition  20b. Place of Disposition  cemetery, cre  1 Crust Cm		ate	Mt. Airy,	
Baltin	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 Is marked any injury or other traumatic av <u>once</u> .		4 Donation 5 Dotter (Specify)	<sup>22</sup> Keeney dand Basford 106 East Church S			
			23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.				Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	ive teat Dis	ence		Onset and Death
8	/Medical Examiner		Due to (or as a consequence of):				1 '
	nsit	Examiner	Sequentially list conditions, if any learning the cause. Enter Underlying Cause (Disease or injury)				
8760, <	cate be executed physician and the burial-transit		that initiated events resulting in death) Last   C. Due to (or as a consequence of):				
687	ificate I g physi as the k	edicai	d				
.O. Box	The law requires that the death certificate be executed tte has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Me		□Ectopic pregnancy □ Other (specify)		23d. Date of d Month	elivery Day Year
ds, P.(	ires that th signed by d be detacl	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.			to the cause of death?
Records,	aw require is been sig 2 should b	Completed			24a. Was a		autopsy findings available o completion of cause of
		Com			autop perfor 1  Yes	med? death?	es 2 No
Vital	Physician: Th rthis certificate ral director, pag	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie	26. Place of Death ent 3 DOA Other: 4 No rsing Hor		ne) lence 6 ⊡Other (Sp	pacify)
Division of	ding After fune	tion: T	27. Manner of Death   Death   28a. Date of Injury   28b. Time of I			ow injury occurred	ecity)
Divis	or A ifter Jirac in by	Certification:	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, si building, etc. (Specify)	treet, factory, office	28f. Location (S City or Tow	Street and Number or I m, State)	Rural Route Number,
	To the Hospital or within 24 hours afte To the Funaral Dirac completely filted in the completely	edical (	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, dea 2 Medical Examiner: On the basis of examination and/or in and manner stated.	th occurred at the time, date and place, a nvestigation, in my opinion, death occurre	and due to the o	cause(s) and manner a date and place, and du	as stated. ue to the cause(s)
	To the comp	2	29b. Signature and title of certifier	29c. License number D 16428	2	29d. Date signed (Mor	nth, Day, Year)
'	1		30. Name and address of person who completed cause of death (Item 23a) (Type	76		7118	108
	-97		Casper E. Cline III, M.D. 300	West Ninth Street,	Freder	ick, MD 21	L701
	Sta Registr		31. Date filed (Month, Day, Year)  APR 2 2 2005  P. Registrar's Signature				

Joshua Pruitt 05–2266 AKG

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

266			1 10400	State of Maryland / De	partment of H		•	no Legible.	
			1 - For State Registrer		ertificate of L		, ,	. No 2005	12701.
			Decedent's Name (First, Middle, Las				2. Date of Death		3. Time of Death
	Physici /Medic		JOSHUA RA	NIDALL PRUITT	SR		March 30	Day Year 7	9:31 P M
	Examin		4a. Fecility Name (If not institution, give	street and number)	4b. City, Town, or	Location of Death		4c. County of Death	) 102 2
		-\$	Peninsula Regional		Salisb			Wicomico	
	Funeral Director		5. Social Security Number 6. Se 1	ex. M 2□ F  7. Age (In yrs. last birthda Yrs.	Months Days	Hours Min.	B. Date of Birth Month, Day, Y	9. Birtho Coun	place (State or Foreign
	land ow		10a. State 10b. County	10c. City, Town or	Location			1	0d. Inside City Limits
	the Mary 28e-f sh notified	Funeral Director	MD WICOM	1100 WILL	10f. Zip Code		100	. Citizen of What Cour	1, Yes 2 □ No
	3a or	i Di	8436 NEWHOPE	70	מרסומ			USA	.,,
	death	nera	11. Marital Status		3. Was Decedent of Hi	spanic Origin? (Spec n, Mexican, Puerto R	ify Yes or No-	14. Race - Americ	
21215-0036	iges 1 and 2 should be filed within 72 hours efter death with the Maryland it of Health and Mental Hygiene.  If item 27 is marked other than "natural", or items 23a or 28e-f show or other traumatic event, the Macheal Eathning must be notified at or other traumatic event, the Macheal Eathning must be notified at		1 ☐ Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 Xio If Yes, Give Year or Dates:	1 ☐ Yes 2 No	Specify:	ican, etc.)	Black, White,	ITE
5 0	72 ho	Completed by	15. Decedent's Ed (Specify only highest gra-	lucation 16a. De de completed) (G	cedent's Usual Occupa ive kind of work done do b. DO NOT use retired,	ation during most of working	g 16	b. Kind of Business/Ind	dustry
121	within ne.	mpi	Elementary/Secondary (0-12)	College (1-4or 5+)				1.1001.10	
S	Hygie Hygie other t		17. Father's Name (First, Middle, Last)	110	UMBER	18. Mother's Name	(First, Middle, Ma	JUMING	
an	d be antal	To Be	CLONIE CLEVLAN			ANNIE L			
Maryland	should nd Men marke	F	19a. Informant's Name/Relationship (7		ailing Address (Street a			City or Town, State, Zip	Code)
	and 2 lealth a m 27 ls		BETTY ANN PRUIT	T WIFE 843	LNEWICK	REDOW	LLAST	s.mo	11874
ore	es 1 s of He fitem r oth		20a. Method of Disposition  1 Burial 2 Cremation 3		sposition (Name of crematory or other place	Θ) Da	te 20	c. Location - City or To	wn, State
Ĕ	nit. Pag vartment ortant: It injury o		4 □ Donation 5 □ Other (Specify		2 Cremato	Ry 4/2/6	5 3	AUSBURY, M	1081 B. CL
Baltimore,	permit. Pages Department of h Important: If ite any injury or of		21. Signature of Funeral Service Licen	see	22. Name and Addres	is of Facility	KIME PC	BOX 61	
	707 a 0		CATEMATORICAL	plications that caused the death. Do not	BIVALV	EMDZI	514		A
	Physician /Medical Examiner	ner	shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate gause. Enter Underlying		phy xie a	nd ches	t injun	ries	Approximate Interval Between Onset and Death
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<u>α</u>	res that igned b be deta	by Pł	Part II. Other significant conditions of	ontributing to death but not resulting in the	underlying cause give	en in Part I.	23e. Did toba	cco use contribute to th	e cause of death?
ord	w require been sig should b	0					1 🗆 Yes	2 No 3 Prob	ably 4 □Unknown
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Division o	tending death. tor: After the fune	Certification;	27. Manner of Death  1 Natural 5 Pending 2 Naccident investigation 3 Suicide 6 Could not be 4 Homicide determined	13-10-03	y M Work	Yes 2 No	sent the	ipped, pinni et and Number or Aura	I Route Number,
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•	3		I him his	MID	OCI	ME,	Ma	arch 31, 20	U5
	19			completed cause of death (Item 23a) (Typ M, D	•	nn Street	Baltimo	ore, Maryla	nd 21201
(4)	Sta Registr		31. Date filed (Month, Day, Year)  ADD 1 2 2	32. Agistrar's Signature	Cart.				

			For 1 State	State of M	laryland /	•				and M	ental Hy	giene	000	the state of	ros.
_			Registrar			Cen	ilicate	e or L	Death		2. Date of De	Reg. No.	ـرلللـ	13/9	
	Physicia	an	1. Decedent's Name (First, Middle, Las								Month	Day		3. Time of De	
	/Medic		James Anthony  4a. Facility Name (If not institution, give	Pazie			4h City	Town or	Location o	of Death	April		2005 County of Dea	12:14 I	
	Examin	er	Suburban Hospital		,		-	Beth		n Doain			ontgome		
	Funeral		5. Social Security Number 6. S		ge (In yrs. last i	birthday)_	If Under	1 Year	If Under 2		8. Date of Bir	th	9. Bir	thplace (State or Fi	oreign
	Director		070-32-5734	<b>Ø</b> M 2□F	64	Yrs.	Months	Days	Hours	Min.	June 2	5, 19	940 Bro	oklyn,NY	
	pu ,		Usual Residence of Decedent  10a. State 10b. County		10c. City, To		ntina							10d. Inside City L	
	shov	'n	,											1½ Yes 2	
	the N	Director	Maryland   Montgome	ery	Chev	y Cha	10f. Zip	Code				10a Citi	zen of What C		
	with Se or	ā	4450 S Park Ave.				TOT. Lip	208	015		,	_		outiny .	
	ms 2:	Funeral	11. Marital Status	12. Was Decedent		13. W	as Decec			gin? (Spe	cify Yes or No Rican, etc.)		USA 14. Race - Am		
9	after or Ite		1 Never Married 2 Married	Armed Forces						i, Puerto I	Rican, etc.)		Black, Whi	te, etc.	
93	be filed within 72 hours after death with the Maryland ital Hygiene. ad other then "naturel", or Items 23e or 28e-f show event, the Medical Examiner must be notified at	d by	3 ☐ Widowed 4 ☒ Divorced	If Yes, Give Year or Dates:	1962-1	963	☐ Yes :	2 <u>14</u> 1 NO	Specify:				Specify: T	White	
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12	within ene. then "	du	Elementary/Secondary (0-12)	College (1-4or 4	5+)	"Bü	Sin	e S S	furing most	er		ТΥ	avel	Agency	
d 2	e filed within al Hygiene. I other then " vent, the Me	е Сс	17. Father's Name (First, Middle, Last)						18. Mothe	r's Name	(First, Middle			agency	
an	ld be ental ked o	To B	Atilio Pazienza						Josej	phine	Bonag	uere			
Maryland 21215-0036	2 should be and Mental is marked or reumetic ever	-	19a. Informant's Name/Relationship (	Type, Print)	1	9b. Mailing	Address	(Street a	and Numbe	or Rura	l Route Numb	er, City o	r Town, State,	Zip Code)	
	Spermit. Pages 1 and 2 should Department of Health and Men Importent: If item 27 is marke any injury or other treumetic ang.		April Palmerlee/D	aughter	2	.7 Jei	rsey	Rd.	Woo1	lahra	a, N.S.	W. 2	025 Aus	tralia	
ore	of He of He fitem		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐	Removal from State	20b. Place	of Dispositery, cremi	ition (Nan	ne of		Apri]	ate	20c. Lo	cation - City or	Town, State	
Baltimore,	trent thent tent: I		`4 □ Donation 5 □ Other (Specification)	y)	Metro				tory	200	)5			,Virgini	а
3all	Departm Departm Importe any inju		21. Signature of Experient Service Licer	500							ol Fun			20007	
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)	Physician / /Medical		Immediate Cause (Final disease or condition resulting in death)		sclerot		ardio	vasc	ular	Dise	ase			years	
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9	leath certific attending p	0	IF FEMALE:	23c. If yes, outcom-	o of propagator										
Вох	death certifi e attending I d for use as	lan/M	23b. Was decedent pregnant in the past 12 months?	1 Live birth	2 ∏ Fetal dea at time of death	ath 3 ☐	Ectopic pr Other (sp						23d. Date of de Month	livery Day Yea	ır
Ö	the characters that	Physica	1  Yes 2  No 9  Unknown	.9☐ Unknown	at time or death	. 50	Oli lei (Sp	- Cily/							
s, P	s that the	by PI	Part II. Other significant conditions	ontributing to death	but not resulting	g in the un	derlying c	ause give	en in Part I.		23e. Did	obacco u	ise contribute t	the cause of deat	th?
rds	requires that een signed b nould be deta		Renal Failure								1 🗆	Yes 2	<b>⊠</b> No 3 □ P	robably 4 Unk	nown
Record	faw requira as been si 2 should t	plet	GI Bleed								24a. Was		24b. Were a	utopsy findings ava completion of caus	ailable
	n: The licate ha	Completed									auto perfe	psy ormed? 2 <del>⊊</del> No	death?	completion of caus	Se 01
Vital	certifica rector, p	BeC	25. Was case referred to medical examiner?						26. Place	of Death	(Check only				
of V	S S	To	1 ☐ Yes 2 ☑ No	Hospital: 1 Inpat		Outpatient			4 L Nu	rsing Hor	ne 5 ☐ Resi	dence	6 □Other (Spe	cify)	
		on:	27. Manner of Death 1 XNatural 5 ☐ Pending	28a, Date of In (Month, D	jury 28t a <i>y Year)</i>	b. Time of Injury		8c. Injury Work			28d. Describe	how injur	y occurred		
Division	Attending r death. ector: After by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not b		niuny - At home	farm stro	M laston		Yes 2 🔲		28f Location /	Street an	d Number or B	ural Route Number	,
Di	of or Attency after death Director:	ertif	4 Homicide determined	building,	etc. (Specify)	, 10.111, 5116	et, iactor)	r, othog			City or To			urai rioute riumber	,
_	spite ours nerel		29a. Certifier 1 ← Certifying Pt	nysicien: To the bes	t of my knowled	dge, death	оссипед	at the tim	ne, date an	id place, a	and due to the	cause(s)	and manner a	s stated.	
	To the Hos within 24 h To the Fur completely	edical	(Check only 2 Medical Exer	niner: On the basis and manner s	of examination	and/or inv	estigation	, in my op	pinion, dea	th occurr	ed at the time,	date and	place, and du	e to the cause(s)	
	To the within 2 To the complet	Me	29b. Signature and title of certifier	111	. 10		290	c. License	e number			29d. Dat	e signed (Mon	th, Day, Year)	
			1 ym	W -	1711			D205	16			Ap	ril 6,	2005	
	4		30. Name and address of person who												
				, M.D. 54	80 Wisc				5 Che	evy C	chase,	MD 2	0815		
	Sta Regist		31. Date filed (Month, Day, Year)	2005	ii ai s Sigitatura	A Go	rede								

415/05 @ 1214

PAZIENZA SAMES

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** рм John Edward Rzeszut, Sr. 6:15 /Medical April 2005 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Randolph Hills Nursing Home Wheaton Montgomery 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 13€ M 2□ F 172-03-2545 89 Director July 6, 1915 Pennsylvania Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits ral', or Items 23a or 28e-f show Examiner ...ust be notified at 1 Yes & No Maryland Montgomery Silver Spring Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12702 Flack Street 20906 IISA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. 1 TYes 2 No If Yes, Give 1941 – 45 Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White δ 3€ Widowed 4 Divorced natural Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Bus Mechanic Transportation other Alth and Mental Hvr 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Frank Rzeszut permit. Pages 1 and 2 should t Department of Health and Ment Important: If item 27 Is marked Tessie Methoer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) June Bonners/Daughter vinjury or other tr 12702 Flack Street, Silver Spring, MD 20906 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition April 7, 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cemetery 1 4 ☐ Donation 5 ☐ Other (Specify) Silver Spring, Maryland 21. Signature of Funeral Service License 22 Name and Address of Facility. Francis J. Collins Funeral Home Inc 500 University Blvd, W, Silver Spring, MD 20901 23a. Part1. Enter the discusse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause disease or condition resulting in death) (Final **Physician** Carcinoma of Lung /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of injury) Due to (or as a consequence of): Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9☐ Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Alzheimer's Disease, Parkinson's Disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed been 24b. Were autopsy lindings available prior to completion of cause of death? 24a. Was an has autopsy performed? 2 \ No 2 No 1 Yes Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient | 2 | ER/Outpatient | 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Tes 25 No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: After 1 Natural 5 Pending Injury 1 □ Yes 2 □ No investigation 2 Accident Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by t 4 Homicide within 24 hours a 🐒 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 10 D52261 April 5, 2005 DAIL 4+1 30. Name and address of person who completed call selof de-h (Item 23a) (Type, Print) Hugo Circle, Alan R. Segal, M.D. 1517 Silver Spring, MD 20906

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month

gistrar's Signature

Ulola Stevenson 215-20-0575

			For State Registrar	State of Maryland / Depa	artment of Health and I Tificate of Death	Mental Hygie	2000	1270-
			Decedent's Name (First, Middle, Las.			2. Date of Death		3. Time of Death
	Physici /Medio		Viola	D. Stevenson		HoniL	10 2005	1647
	Examin		4a. Facility Name (If not institution, give	street and number)	4b. City, Town, or Location of Deat.	h '	4c. County of Dea	•
_	Francis		5. Social Security Number 6. Se	x 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs.	8. Date of Birth	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	thplace (State or Fore
	Funeral Director		,	□M 2 <b>2</b> F 78 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Your 28 -	26 C	MD
	e Maryland Re-f show Lifted at	ctor	10a. State 10b. County Wicom	10c. City, Town or Lo	Sbury			10d. Inside City Limi
	th with th	Funeral Director	308 Brookdale	. Drive	101. Zip Code 21804	10g	Citizen of What Co	ountry?
2	be filed within 72 hours after death with the Maryland Hygiene. d other then "naturel", or Items 23a or 28e-f show avent, I're Medical Exerciment be notified at	by Funer	11. Marital Status  1 □ Never Married 2 □ Married  3 ※Widowed 4 □ Divorced	1 Tyes 2 No	Nas Decedent of Hispanic Origin? (S f Yes, specify Cuban, Mexican, Puerl I 🗌 Yes 2 🛣 No Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, Whit	
3	2 hou	ted t	15. Decedent's Ed	ucation 16a. Deced	ient's Usual Occupation	16	b. Kind of Business	Industry
7	c * W	Completed	(Specify only highest grade	College (1-4or 5+)	kind of work done during most of wor DO NOT use retired) Jurse's Aide		rent Nu	irsing Hom
2	should be filed within and Mental Hygiene. marked other then imatic event, it a Mi	To Be C	17. Father's Name (First, Middle, Last)	EUN VICTOR	18. Mother's Nar Ber	me (First, Middle, Ma.		)
	2 should and Men Is marke eumatic		19a. Informant's Name/Relationship (7		g Address (Street and Number or Ru			Zip Code)
	f Health item 27 other tr		Robert Steven	20b. Place of Dispo	X 1393 SAL15 bu	11	21802 c. Location - City or	Town, State
	Pag nent ent: I		1 Burls 2 Cremation 3 4 Donation 5 Other (Specify				BAltimo	re, MD
	permit. Pag Department Importent: I any injury o		1. Signature of Funcial Service Licens	91	Name and Address of Famility  7 I SABELLA 5+	bennie 3m		801
	Physician /Medical		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	lications that caused the death. Do not entine cause on each line.  a	er the mode of dying, such as cardiad	c or respiratory arrest		Approximate Interval Setween Onset and Death 2 day
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,	ficate be executed physicien and s the burial-transit	al Examiner	cause. Enter Underlying Cause (Disease or injury that intiated events resulting in death) Last	c.  Due to (or as a consequence of):				
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.0.	The law requires that the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown		Ectopic pregnancy ] Other (specify)		23d. Date of de Month	ivery Day Year
	res that the di		Part II. Other significant conditions co	ontributing to death but not resulting in the un	nderlying cause given in Part I.	23e. Did tobac	co use contribute to	the cause of death?
	quires in sign uld be	ed by	Ischemic	Cardiony pathy		1 Tes	2 □ No 3 1 P	obably 4 Unkno
10001	he law require s has been si ige 2 should l	Completed	Respiratory	Failure )		24a. Was an autopsy performer	d? death?	utopsy findings availal completion of cause of
	ysicien: The is certificate hi director, page	0	25. Was case referred to medical		26. Place of Dea	1 Yes 2 tall 1 Yes 2 tall 1 Yes 2 tall 2 tal	HNo 1 ☐ Yes	2□ No
5	Physicien: r this certifica ral director, I	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient 2 ER/Outpatien	Other	lome 5 Residenc	e 6 Other (Spe	cify)
	ding Afte fune		27. Manng of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury	28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	28d. Describe how	injury occurred	
201212	el or Atte s after de N Directo	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, str building, etc. (Specify)	eet, factory, office	28f. Location (Stree City or Town, S		ural Route Number,
	To the Hospitel or Attend within 24 hours after death To the Funerel Director; completely filled in by the	Medical C		rsician: To the best of my knowledge, death iner: On the basis of examination and/or in and manner stated.				
	To the To the To the Comple	Me	29b. Signature and title of certifier	1	29c. License number	29d.	Date signed (Mont	
		1	Atting to the	lu no	D41813		4/10/21	105
	0		I Mare A Mile	completed cause of death (Item 23a) (Type, M) 201 Pin 32. Registrar's Signature		/ .	4/10/21 ND 2	

Spart !

		1	For And State Registrar	nend It	enus Stat enus 23a	e of Maryla	nd / Depa 7,28a - T	artment of per ME.	Health C874 of Death	6715/	ental Hy Osdinb	giene	05	13798
	Physicia	an	1. Decedent's Nam					1M10			2. Date of De		Year 2005	3. Time of Death
	/Medic Examin		4a. Facility Name (	If not institution	give street ar	nd number)		4b. City, Town		of Death			nty of Death	
			SOUTHER	N MARYL	AND HOS			CLINTO						EORGE'S
	Funeral		5. Social Security N		6. Sex 1 M 2 □	26	rs. last birthday) <b>co</b> Yrs.	If Under 1 Year Months Day		Min.	8. Date of Bir (Month, Da	th ly, Year)	9. Birth	place (State or Foreign ntry)
	Director	-	214-46-0 Usual Residence of			-	58 Yrs.				001. 14	4, 1946	MD	
	yland how		10a. State	10b. County		10c.	City, Town or Lo	ocation					1	10d. Inside City Limits
	th the Marylan or 28a-f show e notitied at	Director	MD	QUEEN	ANNE 'S	SI	EVENSVI							1 ☐ Yes 2 X No
		Dire	10e. Street and Nu					10f. Zip Code				10g. Citizen o	of What Coul	ntry?
	eath w	eral	211 BAY	DRIVE	12 Was	Decedent Ever in	U.S. 13.	21666 Was Decedent o		rigin? (Spe	cify Yes or No	USA 14. B	lace - Americ	can Indian,
10	after dea or Items	Funeral		ried 2 Marri	ed 1 🗆	ed Forces? Yes 2. W∑No		Was Decedent o			Rican, etc.)		lack, White,	
036	ral', o	þ	3 Widowed	4 💆 Divorced	If Yea	s, Give r or Dates:		1 ☐ Yes 2 🗶 N	lo Specify	/: 		Spe	cify: WI	HITE
215-0036	"natural",	Completed	(Spe	15. Decedent cify only highes	's Education it grade compl	eted)	16a. Dece (Give	dent's Usual Occ kind of work dor DO NOT use reti	upation ne during mo	st of worki	ng	16b. Kind of	Business/In	dustry
121	within ane. than	dm	Elementary/Sec	ondary (0-12)	Coll	ege (1-4or 5+)	PRES		rea)			COMMI	NICAT	TONC
d 21	Hygie Hygie ther	ပိ	17. Father's Name	(First, Middle,	Last)		IKES	OFIAN	18. Moth	ner's Name	(First, Middle	, Maiden Sum		LUND
an	id be ental ked o	To Be	EDWARD 1	A. SCHM	IDT. JR				MAR	GARET	VTRGT	NIA STO	MMET.	
Maryland	s 1 and 2 should be filed within 72 ho f Health and Mental Hygiene. Item 27 is marked other than "natu other traumatic event, I'm Medicul	-	19a. Informant's N				19b. Maili	ng Address (Stre						Code)
	s 1 and 2 of Health Item 27 i		CYNTHIA	SIMMS/	DAUGHTE			4 RAINBO						
Baltimore,	of He		20a. Method of Dis 1 ☐ Burial 2	sposition Cremation	3 □Removal		cemetery, cre	osition (Name of matory or other p <b>E_CREMA</b>	TTON		ate	20c. Locatio	n - City or To	own, State
Ë	: Pag tment tant:		° 4 □ Donation	5 Other (S)	oecify)	10	ENTER, 1	LC.			/2005			LE, MD
Bal	permit. Pages Department of B Important: If Its any injury or of		21. Signature of	V M	Afe	The	<u> \ 1</u>	06 SHAME	ROCK RO	DAD,	CHESTE	R, MD	ERAL 1 21619	HOME, P.A.
	Physician		shock, or he Immediate Cause disease or conditi	art failure. List (Final on	complications only one cause	mat caused the degree on each line.	eath. Do not en Cardiac			s cardiac o	r respiratory a	rrest,		Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)		D	ue to (or as alcon:	sequence of):	robable	Myoca	rdia	Infar	ction		(30 min
		e	Sequentially list of any, leading to it cause. Enter Und	onditions, mmediate	bD	ue to (or as a con	sequence of):	7	CIII	$\nu \nu$	1	-		100 10 111
	uted d ansit	Examiner	Cause (Disease of that initiated event	r injury	<b>S</b> .			U			11			
ó	ate be executed hysician and the burial-transit		resulting in death)		D	ue to (or as a con	sequence of):		0	Λ	11/1	ICAL EXAMINER		
3760,	ate be hysici	lcal			d				$\mathcal{H}$	MADO	ROVEDENMED	1012		
89 x	death certificate e attending phys ed for use as the	Physician/Med	IF FEMALE:		220 If ve	es, outcome of pre	agn an ev		CERTIFY	ATION APP		004	Data of dalls	
Вох	that the death cer ed by the attendin detached for use	clan	23b. Was deceded in the past 13	2 months?	10	Live birth 2 F Pregnant at time	etal death 3	□Ectopic pregnal □ Other (specify)	ncy \	V			Date of deliv Month	Day Year
P.O.	the de y the iched	yslo	1 ☐ Yes 2 9 ☐ Unknow			Unknown								
		by PI	Part II. Other sign	ificant condition	ons contribution	g to death but not	resulting in the u	ınderlying cause	given in Part	ı.	23e. Did	tobacco use co	ontribute to t	he cause of death?
トル Vital Records,	v requires been sign should be	ed b	Sub	sdur	3 /	rema	toma	status			1 🗆	Yes 2□No	3 Prol	bably 4 Unknown
000	e taw requ has been je 2 shoul	Completed	Die	abet	201	melli	tus	evac	uation	l 	24a. Was		prior to co	opsy findings available ompletion of cause of
± m	The tare has page	Com	En	d d	coal	Rer	nal o	disec	0 C0			ormed? 25 No	death? 1 🗌 Yes	2□ No
ا ا	Attending Physician: Thir death. ector: After this certificate by the funeral director, pag	Be	25. Was case refe examiner?	rred to medical			101			ce of Death	(Check only	one)		
T o	Physi this c	J.	1 Yes 27		Hospital	npatient	2 ER/Outpatie	TIL SLI DOA				how injury occ		fy)
	ding h. After funer	tlon	1 Netural 2 Accident	5 Pendin		Date of Injury (Month, Day Yeal)			ijury at Vork? □Yes 2 <b>√</b>		Subjec			
ال Division	Attendi r death. sctor: A by the fu	ifica	3 Suicide	6 Could	not be	Place of Injury - A	At home, farm, st				28f. Location		mber or Run	al Route Number,
ā	s affe	Certification:	4 🔲 Homicide			house	ecny)			3			Ave.,	Edgewater
	To the Hospital or Atterwithin 24 hours after de To the Funeral Directo completely filled in by the	edical (	29a. Certifier (Check only one)	Certifying 2 Medical	Examiner: On	To the best of my the basis of exame manner stated.	knowledge, dea nination and/or in	th occurred at the ovestigation, in m	time, date a y opinion, de	and place, eath occurr	and due to the ed at the time,	cause(s) and date and plac	manner as se, and due t	stated. to the cause(s)
	To th Withir To th	M	29b. Signature an	d title of certifie	r			29c. Lice	ense number	2-0		29d. Date sig	ned (Month,	Day, Year)
			► AG	uplle	, M	D		DO	06	154	4	04	05	105.
			30. Name and add	dress of person	who complete	d cause of death (	01 SU		ROF	AD #	307	CLI	70	N, MD
	Sta Regist	ate rar	31. Date filed (Mo	APR -	7 2005	32. Registrar's S	ignature	Garle						

		1 - State Registrar	State of Marylan		rtificate of I		-	giene Reg. No. 2	5 1270
Physici /Medio		1. Decedent's Name (First, Middle, Last Evelyn H. S	mith				2. Date of De. Month April	Day 20	3. Time of beaux 05 1:07 P
Examin	er	4a. Facility Name (If not institution, give Holy Cross Hosp	ital			ver Spr	ing		ontgomery
Funeral Director		5. Social Security Number 6. Se 242–36–5983 15 Usual Residence of Decedent	34 00 =	77 Yrs.	If Under 1 Year Months Days	If Under 24 Hr. Hours Mir		9, 1927 N	Birthplace (State or Foreig Country) orth Carolin
Maryland -f ehow	tor	10a. State 10b. County  DC	10c. City	y, Town or Lo	cation Washin	eton			10d. Inside City Limit
72 hours after deeth with the Maryland naturel', or iteme 23a or 28a-f ehow deat Examirer must be netified at	i Director	10e. Street and Number 4014 E1y P1a	ce, S.E.		10f. Zip Code	20019		10g. Citizen of Wha	t Country?
irs after deet ii, or Iteme	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☒ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2♣ No If Yes, Give Year or Dates:		Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2 ☐ No	ispanic Origin? ( n, Mexican, Pue Specify:	Specify Yes or No- rto Rican, etc.)	14. Race - A Black, N Specify:	American Indian, White, etc. Black
permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Heelih and Mental Hygiene. I be partment of Heelih and Mental Hygiene. I enterwed other than "naturelt, or tieme 23 a or 28a-f ehow eny injury or other treumatic event, it a Modical Examinational be notified at once.	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation	(Give lite.	dent's Usual Occupa kind of work done of DO NOT use retired	during most of wo )	orking	16b. Kind of Busin	ess/Industry
ld be filed v ental Hygie ked other t ic event, III	To Be Co	12th 17. Father's Name (First, Middle, Last) Henry Hill		<u> </u>	urrency E			Government Government	rnment
nd 2 shou lith and M 27 ie mar r treumat	-	19a. Informant's Name/Relationship (T)  Matthew Smith -			ng Address (Street a			or, City or Town, Sta	te, Zip Code)
Pages 1 and the count of Hee ent: If item ury or othe		20a. Method of Disposition  1 X Burial 2 Cremation 3 F  4 Donation 5 Other (Specify)	Removal from State	lace of Dispo emetery, crer	sition (Name of natory or other place oln Cemet	θ)	Date	20c. Location · City	or Town, State
Departr Departr imports eny inj		21. Signature Funeral Service Licens	II Trocu		4001 Ben	ning Rd	., N.E. V	uneral Ho Vash., DC	
hysician /Medical Examiner		23a. Parf.1 Enter the disease, or complete shock, or heart failure. List only of smediate Cause (Final disease or condition resulting in death)	ne cause on each line.  Respirate  Due to (or as a consequ	ory Ar		g, such as cardia	ic or respiratory ar	rest,	Approximate Interval Between Onset and Death
ficate be executed physician and is the burial-transit	ai Examiner	Sequentially list conditions, and any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of the consequence of t	ncer lence of):	ar.				
The law requires that the death certificate ate has been signed by the attending phy page 2 should be detached for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \( \text{Yes} \) 2 \( \text{No} \) 9 \( \text{Unknown} \)	3c. If yes, outcome of pregna. 1	ncy death 3	Ectopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year
quires that in signed by uld be deta	by	Part II. Other significant conditions con	ntributing to death but not resu	ılting in the ur	nderlying cause give	en in Part I.			e to the cause of death?  Probably 4 Munknown
	Completed						24a. Was a autop perfor	sy prior	
within 24 hours after death.  To the Funerei Director: After this certificate completely filled in by the funeral director, pag	tion; To Be	27. Manner of Death 1 XNatural 5 Pending	lospital: 1 ☐ Inpatient 2 🕅 28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of Injury	28c. Injury Work	ar: 4 🗆 Nursing I		ne) lence 6  Other (S ow injury occurred	Specify)
s after death	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, stre		AR S INO	28f. Location (S City or Tow		r Rural Route Number,
within 24 hours afte	edicai	29a. Certifier (Check only one) 1 Certifying Physical Exami	sician: To the best of my knowner: On the basis of examinat and manner stated.	wledge, death ion and/or inv	occurred at the tim restigation, in my op	e, date and plac vinion, death occ	e, and due to the durred at the time, o	cause(s) and manne date and place, and	r as stated. due to the cause(s)
within 2 To the	M	29b. Signature and title of certifier	et let			61390	2	29d. Date signed (M 4, 7. ©	
		30. Name and address of person who conclude Charle 31. Date filed (Month, Day, Year)		00 For	rest Glen	Rd., Si	lver Spr	ing, MD	20910

			101	artment of Health and Mental Hygiene
	Physici	an	Decedent's Name (First, Middle, Last)	Reg. No.  2. Date of Death  Month  Day  Year  3. Time of Death
	/Medic Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death  4c. County of Death
	Funeral Director		Doctor's Hospital         5. Social Security Number       6. Sex 1	Lanham Prince George's    If Under 1 Year   If Under 24 Hrs.   8. Date of Birth (Month, Day, Year)   9. Birthplace (State or Foreign Country)   March 4 1919   Washington, DC
0000	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Physiene Important: If item 27 is marked other trun "natural", or Items 23a or 28a-f show any figury or other treumatic event, the Medical Examination content and the ricitlish at ance.	d by Funeral Director	1 ☐ Never Married 2 ☐ Married   tx☐ Yes 2 ☐ No Armv	157V 051V-
yiarid z 1 z 1 3-0030	d be filed within 72 h intal Hygiene ed other than "natu event, the Medica	Be Completed	(Specify only highest grade completed) (Give Elementary/Secondary (0-12) College (1-4or 5+)	dent's Usual Occupation kind of work done during most of working DO NOT use retired)  al Police Officer Government  18. Mother's Name (First, Middle, Maiden Sumame)  Ella K. Stinson
, mary	and 2 should lath and Me of 1s mark er treumation	To	19a, Informant's Name/Relationship (Type, Print) 19b. Maili	ng Address (Street and Number or Aural Route Number, City or Town, State, Zip Code) Copernicus Dr. Lanham, Maryland 20706
pallimore	Pages 1 ament of He ant: If item ury or other		'4 □Donation 5 □ Other (Specify) Riverdal	c Crematory 4/13/05 Riverdale, Maryland
ם D	Dermit Depart Import any Inj once.		1 C 3	2. Name and Address of Facility J. B. Jenkins Funeral Home 474 Landover Road Landover, Maryland 20785
•	Physician /Medical Examiner		23a. Part. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate	Per the mode of dying, such as cardiac or respiratory arrest,  Approximate Interval Between Onset and Death  Pecular Visual VICES
,00790	icate be executed physician and s the burial-transit	edical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):	
O. Box	law requires that the death certific as been signed by the attending p 2 should be detached for use as i	Physician/Me		Ectopic pregnancy 23d. Date of delivery Month Day Year
cords, F	w requires that the de been signed by the should be detached	by	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?  1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown
Į.	The his page	Completed	Cerebsevasales Ho	24a. Was an autopsy performed?  1 Yes 280 No 24b. Were autopsy findings available prior to completion of cause of death?  1 Yes 280 No 1 Yes 2 No
ivision of vital	ding Phy  After this funeral d	Certification: To Be	25. Was case reterred to medical examiner?  1 ☐ Yes 2 ☒ No  1 ☐ Yes 2 ☒ No  27. Manner of Death 1 ☒ Natural 5 ☐ Pending 2 ☐ Accident investigation  1 ☒ Natural 5 ☐ Couldeath	
	Hospitel or Att     24 hours after di     Funerel Direct etely filled in by t		3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)	City or Town, State)
	To the Hospitel or Attent within 24 hours after death To the Funerel Director: completely filled in by the	Medical	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, deat of the basis of examination and/or in and manner stated.  29b. Signature and title of certifier	roccurred at the time, date and place, and due to the cause(s) and manner as stated, vestigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  29c. License number  29d. Date signed (Month. Day, Year)
9	Tu		30. Name and address of person who completed cause of death (Item 23a) Type.	Print) DPINDER SINGH M.S. C. C. C. C. C. C. C. C. C. C. C. C. C.
	Sta Registr		31. Date filed (Month, Day, Year)  APR 1:1 2005	de cocare 11) Dotte

Billie F. Smith Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 05-02686 State of Maryland / Department of Health and Mental Hygiene DOS 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death <sup>Day</sup> 2005 April **Physician** Year Smith Fedora 16, 2207 p /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 12903 McMullan Highway Bowling Green Allegany If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 8. Date of Birth Sep 26, 1933 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2 🖫 F 220-28-9330 **Director** Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location Items 23a or 28a-f show 10d. Inside City Limits MD Allegany Rawlings Director 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 17900 First Street 21557 USA death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian The Medical Examination Black, White, etc. Pages 1 and 2 should be filed within 72 hours atter nent of Health and Mental Hygiene. ont: If item 27 is marked other than "natural", or Ite 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Yes 2 No Specify: þ Specify: white 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home other treumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Elmer Charles Hinebaugh Josephine E. (Lyons) Hinebaugh 2 19a. Informant's Name/Relationship (Type, Print)
JoLynn Sullivan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12903 McMullen Hwy SW Cumberland MD 21502 daughter 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State 5 1 ☐Burial 2 ☐ Cremation 3 ☐ Removal from State Deer Park Cemetery permit. Page Department of Importent: If any injury or once. 4/21/2005 Deer Park MD ' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. NamScarbelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician MULTIPLE INTRIES /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit and certificate be exe Due to (or as a consequence of) the attending physician Physician/Medical as the l IF FEMALE: use 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy ō in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No should be detached 9 Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2. No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 certificate has autopsy performed? 18 Yes 2 No Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other 4 Nursing Home 5 Residence 6 Other (Specify) at Scene 1 XYes 2 □ No 2 this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred SUBTECT HIT AND RWY CVER 27. Manner of Death 28b. Time of Certification; or Attending After POVE DON 1 □Natural 5 Pending SUBTECT IC: CTPM 4116105 1 🗌 Yes investigation 2 Accident VEHICLE BY 6 Could not be 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number,.. City or Town, State) 12903 TCMVUANHWY, Mi determined ROAD 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and male as success.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

P.O. Box 68760, Division of Vital Records, within 24 hours after death. To the Funerel Director: A illed in by Hospitel

altimore, Maryland 21215-0036

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RUBIO MD

OCME

29c. License number

29d. Date signed (Month, Day, Year) April 17, 2005

111 Penn Street Baltimore, Maryland 21201

State Registrar

3

Month, Day, Year) APR 2 2 31. Date filed (Month,

(Check only one)

29b. Signature and title of certifier

			State of Maryland /		rtment of H		_	- 9	1105	1381	n o
			Registrar  1. Decedent's Name (First, Middle, Last)		uncate of L	Jean	2. Date of De	Reg. No: ath	. 0 0 0	3. Time of D	Death
	Physici	an	Catherine Cec	ilia	Strunk		Month April	Day			М
	/Medic		4a. Facility Name (If not institution, give street and number)	1114	4b. City, Town, or	Location of Dea			County of Death	8:15	Р
	Examin	er	19620 Shepherdstown Pike		Boons						
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last to	birthday)	If Under 1 Year	If Under 24 H	rs. 8. Date of Birt	ih .	Washir 9. Bjrth	place (State or	Foreign
	Director		216-38-0549 1□ M 2 🔀 F 64	Yrs.	Months Days	Hours Mi	n. (Month, Da August		Cou	aryland	
	<b>D</b> .		Usual Residence of Decedent								
	aryiar show	ايا	10a. State 10b. County 10c. City, To	wn or Lo		_				10d. Inside City 1 ☐ Yes	
	8e-f	Scto	Maryland Washington			sboro					2 23 140
	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28e-f show the Madical Examiner must be notified at	Funeral Director	10e. Street and Number 19620 Shepherdstown Pike		10f. Zip Code	1713		log. Citi	izen of What Cou		
	s 23s	rai		12 1			(Specify Vos or No		14. Race - Ameri		
	item Item	Ë	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Married 1 7 9 2 2 No	IS. V	Yes, specify Cubai	n, Mexican, Pue	(Specify Yes or No erto Rican, etc.)	-	Black, White,		
38	urs af	by	3 Widowed 4 Divorced Year or Dates:	1	☐ Yes 2 XNo	Specify:			Specify: Wh	ite	
5-0036	2 hou	Completed			ent's Usual Occupa			16b. Ki	ind of Business/In	ndustry	
2	hin 7 9. Mad Mad	pje	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	life. D	kind of work done d OO NOT use retired,	uring most or w	orking				
2	od wit	P C	12	F	Homemaker				Home	:	
aryland 2121	be filed tat Hygir d other event, II	Be	17. Father's Name (First, Middle, Last)			18. Mother's N	ame (First, Middle,	Maiden	Sumame)		
<u>ya</u>	2 should be filed within 72 hours after death with the Marylan and Mental Hyglene. Is marked other than "natural", or items 23a or 28e-f show aumatic event, the Modical Examiner man be notified at	၉	Richard Miller				rtle Patt		le le		
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ຜົ	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any injury or other traumatic ev		Allen E. Strunk (Husband) 19 20a. Method of Disposition 20b. Place	of Disno	Shepherd	stown P	ike Boons	sbor	o, Maryl	and 217	/13
altimore,	ges if ite or of		1 ☐ Burial 2 XCremation 3 ☐ Removal from State	tery, степ	natory or other place		2005		1		
Ë	it. Pa rtmer rtent njury		* 4 □Donation 5 □Other (Specify) Smith  21. Signature of Funeral Service Licensee		g Cremato Name and Addres				thsburg,		ınd
Ba	Depa Impo any i		Davis M01414				J.L. I e. Smiths		Funera		702
		-	23a Partt. Enter the disease, or complications that caused the death. Do						y, maryr	Approximate	
	a		shock, or heart failure. List only one cause on each line. Immediate Cause (Final					A.4		Onset and De	eath
-	Physician /Medical		disease or condition resulting in death)  a. Due to (or as a consequence)	24	ARCIN OT	A OF	LUNG.	100	77STTTC	8 Mary	771 S
П	Examiner			e 017.		70	BRAIN				
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	e of):							-
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o	an an rial-tr		resulting in death) Last Due to (or as a consequence	e of):							
8760,	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medical									
9	ing pt	Med	IF FEMALE:								
Вох	leath certific: attending pl	lan/	23b. Was decedent pregnant in the past 12 months?		Ectopic pregnancy			1	23d. Date of delive Month	ery Day Ye	ear ear
	the a	/sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 4 ☐ Pregnant at time of death 9 ☐ Unknown	5 🗀	Other (specify)		•			,	
О. О.	that the de hed by the a detached f		Part II. Other significant conditions contributing to death but not resulting	in the ur	iderlying cause give	n in Part I.	23e. Did to	obacco u	ise contribute to t	he cause of de	ath?
ds,	ires tha signed d be del	d by			. , ,		121	es 2[	□No 3 □ Prot	bably 4 🗆 Un	nknown
Ö	w require been si should k	Completed					24a. Was	an	24b. Were auto	assy findings as	vailable
ž	has ge 2 s	mp					autop		prior to co death?	empletion of cau	use of
Vital Records,		e Co	OF Ween and referred to modical			00 Diversión		2 No	1 🗆 Yes	2 No	
₹	ysician: is certific director,	0	25. Was case referred to medical examiner?  1  Yes 2 No  Hospital: 1 Inpatient 2 FR/C	Outpation	t 3□ DOA Othe		eath (Check only o		6 □Other (Special	6.1	
Division of	Attending Physician: or death. ector: After this certifici by the funeral director.	n: To		. Time of	28c. Injury Work		28d. Describe h			<i>y</i> /	
lon	tending Ph leath. tor: After th the funeral	ation	1 Natural 5 ☐ Pending (Month, Day Year) 2 ☐ Accident investigation	Injury		es 2 □No					
Vis	or Attendi after death. Director: A in by the fu	ifica	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, building, etc. (Specify)	farm, stre	eet, factory, office		28f. Location (S City or Ton		d Number or Pura	al Route Numbe	ΘΓ,
	s afte	Certification:	Guiding, ste. (speedily)				0.0, 0., 10		/		
	To the Hospitel or At within 24 hours after d To the Funeral Direct completely filled in by	edical	29a. Certifier 1 Certifying Physician: To the best of my knowled 2 Medical Examiner: On the basis of examination a								
	the H in 24 the F the F		one) and manner stated								
	To To con	Σ	29b. Signature and title of certifier		29c. License	numoer		esu. Dat	e signed (Month,	∪ay, rear)	
•	4		Vala Xof Bookin		1 23	8872		41	18/05	~	
	4		30. Name and address of person who completed cause of death (Item 23a	i) (Type, I	Print) JUIT	6 150	Main D		HAGORS	TOWN,	,
	-010	<b>t</b> o	31. Date filed (Month, Day, Year) 32. Registrar's Signature	11110	DICTOR	TL CA	THUS K	7	1-(1)	21142	
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature APR 2 2 2005	See See	7					•	
			1-4-4								

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#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar 1-Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day: April **Physician** 4:04 A M 2005 CLAYTON MAURICE SMITH /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Bryans Road Charles 6908 Heather Drive If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) APRIL 7, 1961 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral 1**X** M 2□ F WASHINGION, D.C. 43 Director 213-84-4518 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show Examiner must be notified at 1**X** Yes 2 □ No 8030 MARSHALL CORNER ROAD, POMFRET Director MARYLAND CHARLES 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number UNITED STATES 8030 MARSHALL CORNER ROAD 20675 Itams 23a death Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.
ant: If item 27 Is marked other than "natural", or Its ury or other traumatic event, the Medical Evantural. Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: by Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry condary (0-12) College (1-4or 5+) 12TH GRADE LABORER - BRICK LAYER CONSTRUCTION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be THELMA WASHINGTON FLORENCE ROBERT JEROME SMITH 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8030 MARSHALL CORNER ROAD / P.O. BOX 85, POMFRET, MARYLAND 20675 THELMA FLORENCE / MOTHER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. ST. JOSEPH'S CHURCH CEM. APRIL 13,2005 | POMFRET, MARYLAND \* 4 □ Donation 5 □ Other (Specify) rat e of Figural Significationsee

LYDIA C. THONNION JUNSON M00583 THORNION FUNERAL HOME, P.A. 3439 LIVINGSTON ROAD, INDIAN HEAD, MARYLAND 20640 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician wound aunshot /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed burial-transit Exam Due to (or as a consequence of): attending physiclan Box 68760 Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) o detachad 9□ Unknown ۵. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ cate has baen sig , page 2 should b 1 🗌 Yes 2 **D** No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

Yes 2□ No 24a. Was an autopsy performed 1 Yes 2 🗌 No Hospital or Attending Phyalcian: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 KOther (Specify) at Scene 2 1X Yes 2 □ No this funeral 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification; After 5 Pending 1 Natural 03:54 4-6-05 1 ☐ Yes 2 XNo after death. investigation 2 Accident filled in by the 3 🔲 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide resine another within 24 hours a To the Funeral C 5 nce 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and dust to the cause(s) and manner as stated.

XXMedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier OCME April 07, 2005 ame and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street Baltimore, Maryland 21201 CA-OLLAKE Date filed (Month, Day, Year) 32. Pagistrar's Signature State

Registrar

DHMH 17 Rev 1/2001

APR 1 1 2005

	State of Maryland / Department of Health  1- For Amend Items 25,27,28a-f per MF CS 42,04/21/05 ft	thb	eg. No: 005 13804
Physician	Decedent's Name (First, Middle, Last)     MARGURITE TOPPER	2. Date of Death	
/Medical Examiner	4a. Facility Name (If not institution, give street and number)  GARRETT COUNTY MEMORIAL HOSPITAL  OAKLAND MARY	LAND	4c. County of Death GARRETT
Funeral Director	5. Social Security Number 234-44-1816  6. Sex 1 M 2 F 7. Age (In yrs. last birthday) 93 Yrs.  1 M Onths Days Hours  Usual Residence of Decedent	8. Date of Birth (Month, Day, 10 /17/1)	Year) 9. Birthplace (State or Forei Country) WV
a or 28a-1 show the notified at Director	10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limi 1 ☐ Yes 2 ☑ N
23a or 28a-f st ust be notified ai Director			og. Citizen of What Country? UNITED STATES
at, or items	1	an, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: WHITE
ygiene. 14. It a Madical Ex Completed b	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  12  16a. Decedent's Usual Occupation (Give kind of work done during modifie. DO NOT use retired)  BEA	ost of working	16b. Kind of Business/Industry BEAUTY
even Be	17. Father's Name (First, Middle, Last)  18. Moti	her's Name (First, Middle, N	Maiden Sumame)
27 is 27 is r treu	19a. Informant's Name/Relationship (Type, Print)  ELLIOTT OURS  19b. Mailing Address (Street and Number 19b)  HC 70, BOX 502 DA		
ment of Hes ent: If item ury or othe	20a. Method of Disposition  1 🔀 Burial 2 Cremation 3 Removal from State  1 Donation 5 Other (Specify)  20b. Place of Disposition (Name of cemetery, crematory or other place)  ROSEDALE		20c. Location - City or Town, State ARTINSBURG, WV 25401
Depart Importe any inji once.	21. Signature of Funeral Service Licenses 22. Name and Address of Fac	91/ CEMETER	RY RD G, WV 25401
physician and interpretations in the burial-transit and calculations in the burial-transit and calculations in the burial-transit and calculations in the burial examiner and calculations in the burial exami	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):	- 19	
d by the attending pletached for use as	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1		23d. Date of delivery Month Day Year
s been signe 2 should be o	Part I straight and before the straight and before the straight and before the	23e. Did tob	n 24b. Were autopsy findings availab
		perform	ned? death? No 1 □ Yes 2 □ No
After this funeral di	examiner?  Hospital: 1 patient 2 ER/Outpatient 3 DOA Other: 4 N	Nursing Home 5 Resident 28d. Describe how Subject	nce 6 Other (Specify) w injury occurred fell reet and Number or Rural Route Number,
within 24 hours after death within 24 hours after death To the Funeral Director: completely filled in by the Medical Certificat		HC 60, E	Box 98 Thomas WV
within 24 hours a within 24 hours a To the Funeral Completely filled	(Check only one) Medicel Examiner: On the basis of examination and/or investigation, in my opinion, de and manner stated  29b. Signature and title of certifier  D Z665	20	ate and place, and due to the cause(s)  ad. Date signed (Month, Day, Year)  alizkops  hland, Md 21550
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  margaret a Kaiser md 13079 Hamet Hig	lune Car	hland, Ud 21550

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			1 - For State Registrar		Olalo o	· ····································		rtificate			, ,	eg. N2 0 0	5 13805
			Decedent's Name (First,	Middle, Last)						_	2. Date of Dea	th	3. Time of Death
	Physici /Medio		Jess	sie -	Tere	lla					Month /	OS / 20	Year VIIIO PM
}	Examir		4a. Fecility Name (If not ins					4b. City, To	wn, or Loca	ation of Death		4c. County	
				undel	Hed		enter		Map	olis		Ann	e Arunde
	Funeral		5. Šocial Security Number	6. Sex	M 2 <b>X</b> F	7. Age (In yrs <b>96</b>	s. last birthday) Yrs.	If Under 1 Months [		nder 24 Hrs. ours Min.	8. Date of Birth (Month, Day JUNE 2	Year)	Birthplace (State or Foreign Country)
	Director		187-14-5672 Usual Residence of Deced			90	170.	<u> </u>			JUNE Z	, 1908	PĔŇŇŠYLVANIA
	how			County			ity, Town or Lo						10d. Inside City Limits
	Ba-t s	cto	MD AN	NE ARUN	IDEL	F	NNAPOL	IS					1. Yes 2 □ No
	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Iteme 23a or 28a-f show ant, the Medical Examinar must be notified at	Funeral Director	10e. Street and Number 85 MANRESA	ROAD				10f. Zip C	2140	1	1	0g. Citizen of W	
	deat	ner	11. Marital Status	1	12. Was Dece Armed Fo	dent Ever in	U.S. 13.	Was Deceder	t of Hispani	ic Origin? (Sp	ecify Yes or No- Rican, etc.)		- American Indian,
21215-0036	urs after ir, or ite	by Fu	1 Never Married 2	_	1 Tes If Yes, Giv Year or Da	2 X No e		1 ☐ Yes 🛣	_	ecify:	rican, etc.)	Specify.	k, White, etc. WHITE
ŏ	2 hou	ted	15. De	cedent's Educ	ation		16a. Dece	dent's Usual (	occupation			16b. Kind of Bu	siness/Industry
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Maryland	uld be fil Mental H rkad ott tic even	To Be	17. Father's Name (First, M						18. 1	Mother's Nam BESS	e (First, Middle, i L <b>E "UNK</b>	Maiden Sumam NOWN <sup>II</sup>	θ)
Mary	nd 2 sho lith and 1 27 is ma r trauma	•	19a. Informant's Name/Re JOHN ROBERT				19b. Mailii <b>316</b>	ng Address (S QUAIL	treet and N	Number or Aur.	al Route Number CENTREVI	City or Town,	State, Zip Code)
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Itam 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinat must be notified at anone.		20a. Method of Disposition 1 ☐ Burial 2 【***Crem** 4 ☐ Donation 5 ☐ Of		emoval from S	State CHI	Place of Dispo cometery cre- SAPEAK VTER						City or Town, State ILLE, MD
Balti	permit. Departn Imports any inju		21. Signature of Funeral S	ervice License	1000	++	FE.	LLOWS,	Address of F	NBEIN &	NEWNAM	FUNERA	L HOME, P.A.
	1		23a. Part1. Enter the disea shock, or heart failure	ase, or complic	cations that ca	aused the dea	th. Do not ent	er the mode o	f dying, suc	h as cardiac	CENTREV or respiratory arre	est,	Approximate
	Physician		Immediate Cause (Final disease or condition	s. List only on			ower 1						Interval Between Onset and Death
	/Medical		resulting in death)	a.		or as a conse			rica	-V 1 (CV 1 ( C	<u> </u>		
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	ed isit	Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	• 【	Due to (	oras a conse		7.	1 .	_			
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о. В	deat	sicia	in the past 12 months 1 Pyes 2 No	?		ant at time of		Ectopic pregi Other (speci				Mon	th Day Year
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CO	aw require s been sig s should t	Completed									24a. Was ai	1 24b. W	/ere autopsy findings available
æ	The lay	E									autops	ned? de	Vere autopsy findings available rior to completion of cause of eath?
Vital	ysician: The is certificate director, pag	BeC	25. Was case referred to mexaminer?	nedical					26. F	Place of Death	1 ☐ Yes 2 Check onlone		Yes 2 No
<u>-</u>	hysic his ce I direc	2	1 ☐ Yes 2 ☑No	Ho	ospital: 1 🔀 ir	patient 2	ER/Outpatien	t 3 DOA	Other: 4[	Nursing Ho	me 5 🗌 Reside	nce 6 Othe	r (Specify)
ט	ding Phy h. After thi funeral	on:	27. Manner of Death  1 SNatural 5 1	Pending	28a. Date o (Monti	f Injury 7, <i>Day Year)</i>	28b. Time of Injury		Injury at Work?		28d. Describe ho	w injury occurre	d
<u>s</u>	Attending Physician: r death. scror: After this certificator, the funeral director,	cati		nvestigation Could not be				М	1 Tyes				
Division of	al or Attenes atter death	Certification:	4  Homicide	determined	buildin	g, etc. <i>(Speci</i>	nome, farm, str ify)	eet, factory, of	fice		City or Town		r or Rural Route Number,
	To the Hospital or A within 24 hours after To the Funeral Directory completely filled in by	edicai (	29a. Certifier 12 Ce (Check only one) 2 Me	rtifying Physi dicel Examin	cien: To the er: On the ba and mann	sis of examina	owledge, death ation and/or in	occurred at t vestigation, in	ne time, dat my opinion,	te and place, and death occurr	and due to the ca ed at the time, da	use(s) and man ite and place, ar	ner as stated. nd due to the cause(s)
	To th To th comp	M	29b. Signature and title of	entifier /	.0	1.	. 1	29c. Li	cense num	ber	29	d. Date signed	(Month, Day, Year)
			KI	ierli	10	- Ja	sal, h	DD	006	2296		04/1	05/2005
1	NIC		30. Name and address of p	erson who con	npleted cause	_			Da . L	: 4 4	1	1.5 =	ND 21401
	Sta	te	31. Date filed (Month, Da)	Year)	32 Re	200 gistrar's Sign		dical	TOLV K	way,	rtring	pous,	MD 61701
	Registr	-	APR -	7 2005	Sex	we I	x Son	all s					
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		•	1 - State Registrar	ate of Maryland / Dep <i>Ce</i>	artment of He rtificate of D			giene2 () () Reg. No.	5 13806
ĵ.	Physicia	an	1. Decedent's Name (First, Middle, Last)				<ol><li>Date of Dea Month</li></ol>		3. Time of Death
186.5	/Medic	al	Paul Alfred Turner  4a. Facility Name (If not institution, give street	and number)	4b. City, Town, or L	ocation of Death	April	4, 2005	8:05 a M
12	Examin	er	Mariner Health- Bet			esda			
 19%	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday,			8. Date of Birtl (Month, Da)	h 9	Gomery  Birthplace (State or Foreign Country)
	Director		577-34-6486 1□xM	2□ F Yrs.	Mortins Days				Illinois
	pug 🔏		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or L	ocation			<u> </u>	10d. Inside City Limits
	Maryli f sho	ō	Maryland Montgo	mery Rock	ville				1 ☐ Yes 2 <b>X</b> No
	r 28a	Director	10e. Street and Number		10f. Zip Code			10g. Citizen of Wha	at Country?
	th with	alD	11521 Patapsco Driv	re	20852			USA	
	ems	Funeral	11. Marital Status 12. W	/as Decedent Ever in U.S. med Forces? 2/1944-	Was Decedent of His If Yes, specify Cuban,	panic Origin? (Spe Mexican, Puerto F	cify Yes or No- Rican, etc.)	14. Race - Black,	American Indian, White, etc.
36	s afte	by Fu	1 ☐ Never Married 2 ☑ Married 1 If 3 ☐ Widowed 4 ☐ Divorced Y	Tyes 2 No 6/1946 Yes, Give 6/1946 ear or Dates:	1 ☐ Yes 2 🛣 No	Specify:		Specify:	White
21215-0036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "naturel", or Items 23a or 28a-f show eumatic event, the Medical Examplact must be notified at	ed b	15. Decedent's Education	16a. Dece	edent's Usual Occupati	ion	T	16b. Kind of Busin	
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Maryland	be filed tal Hygi d other event, I	Be	17. Father's Name (First, Middle, Last)  George Spencer Tur		1			Maiden Sumame)	
<u>Ş</u>	es 1 and 2 should be of Health and Mental I item 27 is marked or rother treumatic eve	2	J 1		ing Address (Street ar	<u>_</u>	nn Hugo		ate Zin Code)
<u>a</u>	d2st thanc 7 is n treun		19a. Informant's Name/Relationship (Type, F Janet Audrey Turner		1 Patapsco				
	1 and Health tem 27 other to		20a. Method of Disposition		osition (Name of omatory or other place)	D	ate	20c. Location - Ci	
ē	Pages nent of ant: If it		1 Burial 2 □ Cremation 3 □ Remove 4 □ Donation 5 □ Other (Specify)	val from State	aven Cemeter	J		Silver S	ring, Maryland
altimore,	permit. Pages Department of I Important: If its any injury or o		21. Signature of Funeral Service Licensee	1141	2. Name and Address				
m	P P P P P	V. A	John Kyle Collu						ing, MD 20901
v.			23a. Part Enter the disease, or complication shock, or heart failure. List only one ca	ns that caused the death. Do not er use on each line.	iter the mode of dying,	such as cardiac or	r respiratory ar	rest,	Approximate Interval Between Onset and Death
100	Physician		disease of condition	Pneumonia					6 Days
	/Medical Examiner		resulting in death)	Due to (or as a consequence of):					
		J.	Sequentially list conditions, b. —	Due to [or as a consequence of]:					Years
	t f insit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events						
o T	te be executed ysicien and le burial-transit	Exa	resulting in death) Last	Due to (or as a consequence of):					
3760,		cal	d						
39	The law requires that the death certifica are has been signed by the attending phoage 2 should be detached for use as it	Physician/Med	IF FEMALE:			-			
Box	leath certific attending p	lan	23b. Was decedent pregnant		☐Ectopic pregnancy ☐ Other (specify)			23d. Date of Month	
o.	that the de	yslc		Unknown					
<u>α</u>	that I	y Ph	Part II. Other significant conditions contribu	ting to death but not resulting in the	underlying cause giver	n in Part I.	23e. Did to	obacco use contrib	ute to the cause of death?
rds,	quires in sign	ed by	Chronic Renal Failu	re, Cerebrovascu	lar <u>Acci</u>	dent	101	/es 2 <sup>3</sup> √⊡No 3	Probably 4 Unknown
Record	aw requir Is been si 2 should	plet	Coronary Artery Dis	ease			24a. Was		re autopsy findings available or to completion of cause of
æ	The lavate has	Completed					perfo	rmed? dea	ath? ]Yes 2□ No
Vital	ysicien: The is certificate hadinector, page	Bec	25. Was case referred to medical examiner?			26. Place of Death	(Check only o	ine)	
of <	Physicien: this certific ral director,	은	1 ☐ Yes 21X No	1   Inpatient 2   EH/Outpatie		4. A Nursing Hon		dence 6 Other	
		lon	TEMATORAL SEPTEMBER	Ba. Date of Injury (Month, Day Year) 28b. Time Injury	Work?		ou. Describe i	low injury occurred	
Division	deat deat ctor: / the	ertification;	3 Suicide 6 Could not be	Be. Place of Injury - At home, farm, s					or Rural Route Number,
S	after safter	Certi	4  Homicide	building, etc. (Specify)			City or Tov	vn, State)	
	To the Hospitel or At within 24 hours after or To the Funerel Direct completely filled in by	edical (	29a. Certifier (Check only 2 Medicel Examiner:	n: To the best of my knowledge, dea On the basis of examination and/or i	th occurred at the time	e, date and place, a	and due to the	cause(s) and mann	er as stated. d due to the cause(s)
	the H the H the F	Medi	one)	and manner stated.				29d. Date signed (	
)	To Toon	-	29b. Signature and title of certifier	ron, M.D	29c. License				
,	5		\			6552			2005
			30. Name and address of person who comple Pankaj Talwar, M.D	50 W. Edmonts	ton Drive,	#401, R	ockvill	e, MD 208	352
	Sta	ate	31. Date filed (Month, Day, Year) 7 200	32. Agistrar's Signature	1				
	Regist	rar	APK U / 200:	Marie IF 6	Market 1				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Month **Physician** Urella Turner Apr 14, 2005 1:58am /Medical 4a Fecility Name (If not institution, give street end number) 4b. City. Town, or Location of Deeth Examiner Allegany County Nursing Home Cumberland Allegany If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Dec 16, 1918 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2 □ XF Director 220-10-0344 86 Usuel Residence of Decedent Pagas 1 end 2 should be filed within 72 hours after death with the Marylend nant of Heelth end Mental hygiene. Int: If Item 27 ie marked other than "hatural", or Items 23e or 28e-f ehow 10a. Stete 10c. City, Town or Location 10d. Inside City Limits Item 27 ie marked other than "naturel", or items 23e or 28a-f eho other traumetic event, the Medical Examiner must be nortified at MD Allegany Cumberland 1 ☐ Yes 2 ☐ No Funeral Director 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 37 Blackiston Avenue 21502 USA 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian. Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced white 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Beaming Dept. 17. Fether's Name (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Sumame) Be Charles H. Twigg Linda (Shryock) Twigg 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Clyde Turner 37 Blackiston Avenue son Cumberland MD 21502 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of I Important: If Ite any Injury or of pnce. 1 □Xurial 2 □ Cremation 3 □ Removal from Stete Sunset Memorial Park 4/16/2005 4 ☐ Donetion 5 ☐ Other (Specify) Cumberland MD 22. Name and Address of Facility
Scarpelli Funeral Home, P.A. 21. Signature of Funeral Service Licensee 108 Virginia Avenue; Cumberland, MD 21502 23a Part / Ehler the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, speck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be asscuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury Due to (or as e consequence of) Division of Vital Records, P.O. Box 68760, that initiated events resulting in death) Last Due to (or as a consequence of) attanding for usa as Part II. Other significent conditione contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of deeth? 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certifica complataly filled in by the funeral director, I 25. Was case referred to medical examiner? Medicai Certification: To Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Nursing Home 5 ☐ Residence 6 ☐ Other (Specily) 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and plece, and due to the ceuse(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner steted. 29a. Certifier ţ 29b. Signature and 29c. License number 29d. Date signed (Month, Day, Year) of certifie 2 00033280 30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print) Registrar's Signature 625 Kent Avenue Cumberland MD 21502 State Registrar

iysicia	2	1. Decedent's Name (First, Middle, L	Last)							2. Date of De Month	ath	Year	3. Time of Death
Medica		Clyde Ti	llman Wood	lief	Jr.	<del></del>				2/4	/200		10:35 MF
kamine		4a. Facility Name (If not institution, g Anne Arundel M	Medical Cer	rter		A	nnap						l County
neral ector		217-66-1618	. Sex 7. A	ge (In yrs. 49	last birthday) Yrs.	If Under Months		If Under Hours	24 Hrs. Min.	8. Date of Bir	7 955	9. Bir Gray	thplace (State or Foreign bunta) Le Co.N.
描		Usual Residence of Decedent  10a. State 10b. County			ty, Town or Lo								10d. Inside City Limits
Deilli	ctor	Md.		1	_othiar	1							1⊈ Yes 2 No
De no	Director	10e. Street and Number 226 5th. S	treet			10f. Zip	Code 20711				10g. Citiz	en of What Co USA	ountry?
TO USE	Funerai	11. Marital Status	12. Was Deceden	t Ever in U	I.S. 13.			ispanic Ori	gin? (Spe	ecity Yes or No Rican, etc.)	)- 1	4. Race - Ame	erican Indian,
Exa		1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🗓 Divorced	Armed Forces  1 Yes 2  If Yes, Give Year or Dates:	KN0		If Yes, spec 1 ☐ Yes			i, Puerto	Rican, etc.)		Black, Whit	te, etc. Vhite
dical Exs	eted	15. Decedent's (Specify only highest of			16a. Dece (Give	dent's Usua kind of wo DO NOT us	al Occupa	ation during mos	t of work	n <i>g</i>	16b. Kir	d of Business	/Industry
a Me	Completed by	Elementary/Secondary (0-12)	College (1-4or	5+)	life.	bo not us Sheet	ise retired Meta	list				Roofi	ng
ent, I	Be Co	12 17. Father's Name (First, Middle, La.	ist)					18. Mothe	r's Name	(First, Middle,	Maiden :	Sumame)	
atic ev	To B	Clyde Tilli	man Woodli	ef Sr	•				Emn	na Hart			
other traumatic event, the Medical		19a. Informant's Name/Relationship		athor		-				Route Number			
thart		Clyde T. Woodlie 20a. Method of Disposition	6 3/L FO		Place of Dispo					ate		cation - City or	
-		1 X Burial 2 ☐ Cremation 3  4 ☐ Donation 5 ☐ Other (Spec			cemetery, cre. .dowvie				2/1	0/05		ord, N	
any injury o once.		21. Signature of Funeral Service Lic		FS			nd Addres	s of Facilit	S FU	NERAL HO	ME, IN	ic.	
cian	ĺ	23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition	omplications that cause ly one cause on each	ed the deat line.	th. Do not en	ter the mod	de of dying	g, such as	cardiac o	r respiratory ai	rrest,		Approximate Interval Between
			_ a / 1/W/	-1 C	En	cepl	harl	opa	th				Onset and Death
dical liner		resulting in death)	aA   W   Due to (or a.	s a conseq	quence of):	cepl	harl	opa	th	Intoxic		n	Onset and Death
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			1 - For Registrar	State of Ma	arylan		artmen rtificate					giene Reg. No.	2001	)	13809
	Physic /Medi		Decedent's Name (First, Middle, La DAVID	ast)			YENTI	S			2. Date of De April	5 , Day	200°	ar 5	3. Time of Death 10:41P.M
	Examir		4a. Facility Name (If not institution, gir The Ring House	re street and number)					Location o	of Death		4c.	County of E		
	Funeral		5. Social Security Number 6.		e (In yrs.	last birthday)	If Under		If Under		8. Date of Bir	th	Monte 9.	Birthola	ace (State or Foreign
	Director		121-07-6249 Usual Residence of Decedent	1 <del>N</del> M 2□ F		91 Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, Da NOV • 1	, 191	3 Ne	Counti ⊇W \	fork
	e Marylan 3e-f show Liffed st	ctor	Maryland Montgome	ery		y, Town or Lo Rockvil								10	d. Inside City Limits 1 XYes 2 No
	th with th 23a or 24 ust be no	Funeral Director	1801 East Jeffer:	son Street,	#22	29	10f. Zip	Code 20	852				zen of What United		
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than *natural; or Itams 23a or 28e-f show morphy injury or other traumatic event, if a Mydical Examinate rust be nytified at ance.	by	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent 8 Armed Forces? 1  Yes 2 2 1 If Yes, Give Year or Dates:			Was Deced f Yes, spec		spanic Ori n, Mexican Specify:	gin? (Sp i, Puerto	ecify Yes or No Rican, etc.)	-	14. Race - A Black, V Specify:	hite, e	
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212	led withir ygiene. har than it, it e M.	Be Completed	Elementary/Secondary (0-12)	College (1-4or 5		Chief	DO NOT US	e retired,	jist			and	Urbai		of Housing evelopment
Maryland 21215-0036	should be filed nd Mental Hygi i markad othar umatic evant, I	To Be	17. Father's Name (First, Middle, Last Louis	)		Yent			Ne.	llie	e (First, Middle,		Berns		
	and 2 sho salth and n 27 Is m		19a. Informant's Name/Relationship Paul M. Yentis — S	Type, Print) SON		19b. Mailir 1201	ng Address 2 Tra	(Street a ilri	nd Numbe .dge I	or Or Rura Orive	al Route Number Potoma	ac, City o	r Town, Stat Maryla	e, <i>Zip C</i> and	<sup>20854</sup>
Baltimore,	Pages 1. nent of He int: If iten Iry or oth		20a. Method of Disposition  1  Burial 2  Cremation 3    '4  Donation 5  Other (Speci		c	lace of Dispo emetery, cren g Davi	natory or of	her place	rdens		7/2005		cation - City		m, State
Balti	permit. Departm Importal any inju		21. Signature of Funeral Service Lice		0	DO	Name and	Addres V. E	s of Facility	ardt Bor	Funera				and20705
T. B. C. L. Co.	Pnysician /Medical Examiner	94	23a. Part1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate	a. Metasta Due to (or as a	atic a consequ	n. Do not ento  Adenoc  uence of):	er the mode	of dying	g, such as	cardiac (	or respiratory ar	rest,	ie, ne	1	Approximate nterval Batween Onset and Death
68760,	The law requires that the death certificate be executed that been signed by the attending physician and age 2 should be detached for use as the burial-transit	edicai Examiner	cause. Enter Underlying cause, Civesus of Hipping that initiated events resulting in death) Last	c Due to (or as a											
P.O. Box	the death certifice y the attending ph Iched for use as the	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of the little birth the little birth the little birth the little birth the little birth the little birth	2 Fetal	death 3	Ectopic pre Other (spe					2	23d. Date of Month	,	r day Year
ds, P	uires that the de signed by the a ld be detached f	by	Part II. Other significant conditions of coronary artery d	contributing to death buisease; hyp	it not rest erte	ulting in the ur	nderlying ca	iuse give	n in Part I.						cause of death?
Division of Vital Records,		Completed	chronic renal fai	lure							24a. Was a autop perfor	sy med?	24b. Were prior death	to comp	y findings available pletion of cause of
Z E	sician certifi rector	o Be	25. Was case referred to medical examiner?	Hospital:				Othe			(Check only or	,	7		
on of	iding Phys th. : After this funeral di	$\vdash$	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	1 ☐ Inpatier  28a. Date of Injury (Month, Day	y	28b. Time of Injury		c. Injury Work	4 LI INUI	2	ne 5 🗌 Resid 28d. Describe h			3 <i>5</i> 34/5	sted Livin
Divis	Hospital or Attending Physician: 44 hours atter death. Funaral Diractor: After this certific tely filled in by the funeral director.	Certification;	3 Suicide 6 Could not be determined	e Ogo Place of Injur	ry - At ho . (Specify	me, farm, stre	eet, factory,	office		2	28f. Location (S City or Tow	itreet and n, State)	i Number or	Rural F	Route Number,
	To the Hospital or within 24 hours afte to the Eunaral Dir completely filled in	edicai (	29a. Certifier 1  Certifying Ph (Check only one) 2 Medice! Exer	nysicien: To the best on niner: On the basis of and manner stat	examinat	wledge, death ion and/or inv	occurred a restigation,	t the time	e, date and inion, deat	d place, a	and due to the co	ause(s) a date and	and manner place, and d	as state	ed. ne cause(s)
	To the within 24 To the Complet	Me	29b. Signature and title of certifier	) sillows	0			License D005	number 7884				signed (Ma 1 6, 2		
	8		30. Name and address of person who Damien J. Doyle,	M.D. 1801	eath (Item East	23a) (Type, F Jeffe	erson	Stre	et Ro	ockv:	ille, Ma	aryla	and 20	852	
6	Sta Registr		31. Date filed (Month Day, Year) 7	2005 32. Begistra	r's Signal	b. A	restel	,							

		1 - For State Registrar		faryland /		artment of F tificate of		nd Mental Hy	Rag. No.	005	13810
Physic	ian	Decedent's Name (First, Middle, La						2. Date of D	Day	Year	3. Time of Death
/Medi			lee Sheel		3				19, 20		5:00 P. M
Exami	ner	4a. Facility Name (If not institution, giv		•		4b. City, Town, o		Death		nty of Death	
	4	Gilchrist Center 5. Social Security Number 6. S		ice Car		Towson	n If Under 2	Hrs. 8. Date of Bi	eth	1timon	
Funeral Director			_ M 2 1 F	64	Yrs.	Months Days	Hours	Min. (Month, D)	av. Year)	Mars	place (State or Foreign intry) Land
OT.		Usual Residence of Decedent		01				<del>рсг. 3,</del>	1540	TIGE	y Land
rylan how		10a. State 10b. County		10c. City, To	own or Lo	cation					10d. Inside City Limits
a Ma	cto	Maryland Balti	more	Lu	ther	ville					1 ☐ Yes 2 🕅 No
or 28	Director	10e. Street and Number				10f. Zip Code			10g. Citizen	of What Cou	intry?
ath v	ig.	1421 Front Avenu					21093			ed Sta	
faryland 21215-0036 2 should be filed within 72 hours after death with the Maryland and Mantal Hygiene. Is marked other than "natural", or itams 23a or 28a-f show raumatic evant, the Mydical Examiter transi be notified at	Funeral	11. Marital Status	12. Was Deceden	?	13.	Vas Decedent of H f Yes, specify Cuba	lispanic Origi an, Mexican,	n? (Specify Yes or N Puerto Rican, etc.)	0- 14. F	Race - Ameri Black, White,	
21215-0036 Id within 72 hours att giene. er than "natural", or the Mudical Execut	by F	1 ☐ Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 X If Yes, Give Year or Dates			∏Yes 2 <b>X</b> No	Specify:		Spe	cify:	ni to
2 hou		15. Decedent's E	ducation		6a. Dece	lent's Usual Occup	pation		16b. Kind of		nite
21 25 min	Completed	(Specify only highest gra	ade completed) College (1-4o	(5+)	(Give life. i	lent's Usual Occup kind of work done OO NOT use retired	during most ( d)	of working			•
21.	ν	12	-0-		Home	maker			Own	Home_	
nd oe file al Hy u oth	Be (	17. Father's Name (First, Middle, Last,	)				18. Mother	s Name (First, Middle	a, Maiden Sum	ame)	
Via Ment Ment arked	2	Thomas	Evans		She	eler	Marg	aret	R.		Shock
Maryland of 2 should be file the and Mental Hy 27 is marked other traumatic event		19a. Informant's Name/Relationship (				,		or Rural Route Numb		wn, State, Zij	p Code)
P, N and lealth m 27 her ti		Mr. Charles E. A	mos (husb				enue,	Luthervill		21093	
Baltimore, permit. Pages 1 a mportant of Hea mportant: If item my injury or othe 2029.		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Specif.	Removal from State		etery, crer	sition (Name of natory or other plac	· · · · · ·	Date	20c. Locatio		
Itim t. Pa rtmen rtant:				,		rematory	Apr	. 21, 2005	Balt	imore,	, Maryland
Baltimore, Maryland 21215-0036  permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Modical Examiner Lans Le motified at once.		21. Signature of Funeral Service Licer	l l	Brian T				Services Road, Timo			7alley, P.A. 1093
		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that cause one cause on each	ed the death. D	o not ent	er the mode of dyin	ng, such as ca	ardiac or respiratory a	arrest,		Approximate Interval Between
Pnysician		Immediate Cause (Final disease or condition	chr	nic 1	Amp	hosptic	Leve	emin			Onset and Death
/Medical Examiner		resulting in death)	Due to (or a	s a consequen	ce of):						0
Examiner		Sequentially list conditions,	b. —								
V be isi	ine	Sequentially list conditions, if any, leading to immediate cause. Et let distribute Cause (Disease or injury that initiated events	Due to (or a	s a consequenc	ce of):						
760, 19 secuted to be executed ysician and the burial-transit	Examiner	that initiated events resulting in death) Last	cDue to (or a	s a consequenc	ce of):		<del></del>				
7760 1760 Ite be e	cai E			•	,						
			_ 0								
Records, P.O. Box 68 The law requires that the death certificat the has been signed by the attending phy page 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom			le			23d.	Date of deliv	rery
death death	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregnant	2 ☐ Fetal dea at time of death		Ectopic pregnancy   Other <i>(specify)</i>	<i>'</i>			Month	Day Year
P.O. that the de detached is	hys	9 🗆 Unknown	9□ Unknown								
S, F Ss that ses that igned be de	by P	Part II. Other significant conditions of	ontributing to death	but not resulting	g in the u	nderlying cause giv	en in Part I.	23e. Did	tobacco use co	ontribute to t	the cause of death?
Cords w require been signated to		Stroke			_			10	Yes 2□No	3 ☐ Prol	babiy 4 Unknown
Record he law requir	ompleted							24a. Was			opsy findings available ompletion of cause of
	Com							perf	ormed?	death?	
Vital F Vital F ician: Th	BeC	25. Was case referred to medical examiner?					26. Place o	f Death (Check only			716
dis ys	2	1 ☐ Yes ŽÇNo		tient 2 ER/	Outpatien	t 3 DOA Oth	er: 4 🗆 Nurs	ing Home 5 Res	idence 6 V	Other (Specia	MILOSPIE
		27. Manner of Death  1 Natural 5 □ Pending	28a. Date of In (Month, D	iury 28t lay Year)	D. Time of Injury	28c. Injur Wor	k?	28d. Describe	how injury	urred	1.
	ertification:	2 ☐ Accident investigation	1				Yes 2□N				
Division Division of a ster death all Directors and in by the	ıţ	3 Suicide 6 Could not b 4 Homicide determined	286. Place 0: II	njury - At home, etc. <i>(Specify)</i>	farm, str	et, factory, office		28f. Location ( City or To	(Street and Nu wn, State)	mber or Rur	al Route Number,
Doital ours at Distal D	O							1			
Div Div To the Hospital or A within 24 hours after To the Funeral Direct completely filled in by	edicai	29a. Certifier  (Check only one)  Check only 2 Medical Example (Check only one)	niner: On the bes niner: On the basis and manner s	of examination	ige, death and/or inv	occurred at the ting estigation, in my o	ne, date and pinion, death	place, and due to the occurred at the time,	cause(s) and date and plac	manner as s e, and due t	stated. o the cause(s)
To th withir To th	¥.	29b. Signature and title of certifier	0			29c. Licens			29d. Date sig		
		M/ Vian	lus			DS	7830	5(	APRIL	- 19	Zous
		30. Name and address of person who	completed cause of	death (Item 23	а) (Туре,	Print)	1				
22			5, MD (	269 N	1- ()	hades	5 / 13	3 Alteuno	40 21	505	
	ate	31. Date filed (Month, Day, Year)	32. Bagis	trar's Signature						,	
Regist	in y	APR 2 5 21	005   16	w B	-	and I					
DHMH 17 Rev 1/2	2001		-								
				Ul-	RIGINA	l. fee					

			_ FOI	Department of Health and Mer Certificate of Death	ntal Hygiene
	Physicia /Medic		1. Decedent's Name (First, Middle, Last) REGGIE MILTON BLACKWELL,	SR 04	Date of Death Month Day Year 4:00 P M
	Examin	er	4a. Facility Name (If not institution, give street and number) 139 CARVER ROAD	4b. City, Town, or Location of Death 1 URNER STATION	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birth	hday) If Under 1 Year If Under 24 Hrs. 8.  Months Days Hours Min.	Date of Birth (Month, Day, Year) 2 · 25 · 1913  9. Birthplace (State or Foreign Country) VA
	show		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town	/ /	10d. Inside City Limits
	the Mar 28a-f st	Funeral Director	MD BALTIMORE TURNE	R SIATION  10f. Zip Code	1 ☐ Yes 2 MS No
	23e or	al DI	139 CARVER ROAD	21222	usa
920	iges 1 and 2 should be filed within 72 hours after death with the Maryland at of Health and Mental Hygiene.  If I them 27 is marked other than "naturel; or items 23e or 28e-f show if It them 27 is marked other than "naturel; or items to notified a for other treumetic event, it is Medical Eracial at must be notified at	by		13. Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Rica 1 ☐ Yes 2 包 No Specify:	14. Race - American Indian, Black, White, etc.  Specify: BLACK
21215-0036	I within 72 ho iene. r than "natur r e Meulo:	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  3 RD GRADE N A	Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) BURNER	16b. Kind of Business/Industry  BETH . STEEL
Maryland 2	2 should be filed withir and Mental Hygiene. Ie marked other than eumetic event, I'm Ma	To Be C	17. Father's Name (First, Middle, Last)	18. Mother's Name (Fi	irst, Middle, Maiden Sumame) THTE
	and 2 shalth and 27 ie m		19a. Informant's Name/Relationship (Type, Print)  SARAH BLACKWEU  130	Mailing Address (Street and Number or Bural Ro 9 CARVER RD. IURN	
Baltimore,	Pages 1 and 2 nent of Health int: if Item 27 inty or other tre		1 K Burial 2 Cremation 3 Removal from State	Disposition (Name of y, crematory or other place)  ON FOREST  O4 · 28 ·	
Balti	permit. Page Department o Importent: If eny injury or once.		21. Signature of Funeral Service Licensee	22. Name and Address of Eagility VAUGHIN C. GREENE FUI 5151 BALTO NATU PIKE	
	Pnysician /Medical		23a. Part1. Enter the dispase, or complications that caused the death. Do n shock, or heat telled. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of the consequ	Carcinoma	spiratory arrest, Spiratory arrest, Approximate Interval Between Onset and Death
8760,	crate be executed xxx physician and must sthe burial-transit and	Ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin, Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of the control		
P.O. Box 68	ne death certiff the attending hed for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	23d. Date of delivery Month Day Year
	quires that the stand of stands of the stand	by	Party of the symmetric control of the symmetry	the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?  1  Yes
Records,	e law has b	Completed	Renal cell carcin	ома	24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1  Yes 2 No
Vita	sicien: certific rector,	o Be C	25. Was case referred to medical	26. Place of Death (C	
o u	ng fte	- T			. Describe how injury occurred
Division of Vital	or Attendent fler deatl Director: in by the	Certification;	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, far building, etc. (Specify)		Location (Street and Number or Rural Route Number, City or Town, State)
	Hospitel 24 hours a Funerel C	edical Ce	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge and manner stated.		
	vithin To the	Me	29b. Signature and title of certifie	29c. License number	29d. Date signed (Month, Day, Year)
0	O		30. Nine and address of person who completed caus of death (Item 23a) (	Type, Print) 100 No	1 4/24/05 115 Point Bhil
	) Sta	te:	31. Date filed (Month, Day, Year)  APR 2 5 2005  32. Begistrar's Signature	CMO Balt	+2212 CH
	Regist		APR 2 5 2005	Specie	

State of Maryland / Department of Health and Mental Hygiene 20051 - State Registrer Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** April Kelton D. Bauer 2005 2:10P /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Mariner Health of Catonsville Catonsville Baltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) 1**☑** M 2□ F Months Days Hours 214-03-3014 85 Director Maryland Usual Residence of Decedent 72 hours after death with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 7 is marked other than "natural", or items 23a or 28a-f sho) traumatic event. The Medical Erandisc must be notified at 1 X Yes 2 No Directo Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1625 Shakespeare Street 21231 U.S.A. Funerai 12. Was Decedent Ever in U.S. Armed Forces?

1 ★Yes 2 □ No
If Yes, Give WW II Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 WW II 1 ☐ Yes 2 Ø No Specify: If Yes, Give Year or Dates: Completed by 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If item 27 Is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) Contractor Building Trades 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Raymond E. Bauer, Sr. 2 Hanna E. Karow 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 135 Washington Street P.O. Box 720 19a. Informant's Name/Relationship (Type, Print) Linda Orr (Daughter) Delaware City, Delaware 19706 other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State ŏ permit. Page Department of Important: If any injury or 1 4 ☐ Donation 5 ☐ Other (Specify) Balto/Wash Crematory | 4-25-2005 Laurel, Maryland 22. Name and Address of Facility
Witzke Funeral Home of Catonsville, Inc. 21. Signature of Foreral Service Licensee 1630 Edmondson Ave Catonsville, Maryland 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final adenocacinon metastatic **Physician** lyan disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): Examiner death certificate be executed burial-transit attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 Other (specify) the 9 Unknown is certificate has been signed by director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò atheroschate condiounale discre 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an 2E No 1 Yes Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 70 1 ☐ Yes 2 No this 28c. Injury at Work? Certification: Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After Hospital or Attending 1 Natural 5 Pending 1 Tyes 2 No death. investigation after death Director: / 2 Accident the 6 Could not be determined 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral D 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai completely (Check only one) 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D-30972U cause of death (Item 23a) (Type, Print) 30. Name and address of person who completed 670 IN. Chates St Suje 5218 Balline mD LIVE 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item#22, perFH, C842, 4/25/05 TT

			1 - For State Registrar			tificate of L		Rec	g. No.2 1 1 E	12012
Н	Physici /Medic		Decedent's Name (First, Middle, Last)     Cecelia	L.		Bailey	7	2. Date of Death Month	L8 2005	3! Tilme or Death $\bigcirc$ 7:25 p.M
	Examin		4a. Facility Name (If not institution, give str	·		4b. City, Town, or	Location of Death		4c. County of De	path
			Harborside Health 5. Social Security Number 6. Sex	Care 7. Age (In yrs.	Inst hirthday)		imore If Under 24 Hrs.	C. Data of Birth	NA	Estate - Change
	Funeral Director		·	M 20XF 83	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, 1		lirthplace (State or Foreign Country)
P			Usual Residence of Decedent					J-31-		Va
arylar	show	7	10a. State 10b. County	10c. Cit	ty, Town or Loc	ation				10d. Inside City Limits 1 ☐ Yes 2 ☑ No
Med	28a-f	Director	Md Balto  10e. Street and Number	O1	wings M	10f. Zip Code		10	g. Citizen of What	
¥	3a or	ā	110 Twin Willow C	<del>-</del>		2111	7	109		Country
5-0036 72 hours after death with the Maryland	s. sn "neturel", or items 23a or 28a-f show Medical Examiner must be notified at	Funeral		. Was Decedent Ever in U	.S. 13. V		spanic Origin? (Spin, Mexican, Puerto	ecify Yes or No-		nerican Indian,
after	or ite		1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 XNo If Yes, Give		Yes 2 No	Specify:	nican, etc.)	Black, Wi	nite, etc.
21215-0036 d within 72 hours aft	ural',	d by	3 XWidowed 4 □ Divorced	Year or Dates:			. ,		В.	lack
ر ا	29	olete	15. Decedent's Educa (Specify only highest grade	completed)	(Give F	ent's Usual Occupa kind of work done d OO NOT use retired,	ition Juring most of work: }	ng 16	6b. Kind of Busines	ss/Industry
LZ LZ	e t a	Completed	Elementary/Secondary (0-12) 4th grade	College (1-4or 5+) N/A			orker		Private	e Homes
		Be C	17. Father's Name (First, Middle, Last)		·		18. Mother's Name	(First, Middle, Ma	aiden Sumame)	
Maryland d 2 should be file	nd Mental marked c matic eve	To	Preston Phillips				Bertha	Standbac	k	
Mar	7 Is m		19a. Informant's Name/Relationship (Type	e, Print)	432.040		and Number or Rura			
	I 9 E		Latonia Simmons -Gr 20a. Method of Disposition	20b. F	110 Place of Dispos	Twin Will sition (Name of	llow Ct O	wings Mi	11s, Md 2 oc. Location - City of	21117 or Town, State
Pages	0 -		1 X Burial 2 ☐ Cremation 3 ☐ Rei 4 ☐ Donation 5 ☐ Other (Specify)	noval from State	zemetery, crem	Forest Ve	i i		wings Mil	
Baltimore,			21. Signature of Fun ral Service Licent ee		0 1	Name and Addres			ore, Md.	21202 2121
n a	Depa impo any ir		Jakn S.	benno	1	March F.E	L West		oash Ave.	
			23a. Pag 1. Enter the disease, or complica shock, or heart failure. List only one	ations that caused the deat cause on each line.		or the mode of dying	g, such as cardiac o	r respiratory arres	it,	Approximate Interval Between
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	Medical xaminer		resulting in death)	Due to (or as a const	uence of):	./ ^ -	elmi la I	Hann		
		ē	Sequentially list conditions, b.	Dua to (or as a non-seq	uence of):	vasu	Non -	reac		
petno	ansit	Examiner	Sequentially list conditions, Tarry, isadmig to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Hyper	ten so	n				
ڪ ڏڏ	ian an irial-tr		resulting in death) Last	Due to (or as a conseq	uence of):					
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		/Med	IF FEMALE:	c. If yes, outcome of pregna	ancy				22d Date of d	
death cert	attendin for use	Physician/M	in the past 12 months?	1 Live birth 2 Feta 4 Pregnant at time of d	il death 3 □	Ectopic pregnancy Other (specify)			23d. Date of d Month	Day Year
Tat the Co	led by the a detached f	hysl	1 U Yes 2 No 9 Unknown	9□ Unknown						
	been signed t	by P	Part II. Other significant conditions contr	-			n in Part I.	23e. Did toba	cco use contribute	to the cause of death?
oriuge equire	sen si		Degeneral	ve Jon	F 10	Flane		1 🗆 Yes	2 No 3 1	Probably 4 Donknown
OT VITAL HECOFGS, Physician: The law requires t	has be je 2 sh	Completed						24a. Was an autopsy	prior to	autopsy findings available completion of cause of
<u> </u>	ate pag	Con						performe	ed? death? ∃No 1 ☐ Ye	
OT VITA Physician:	is certificate director, pag	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	spital:		Othe	26. Place of Death			
o a	or this aral dii	-	27. Manner of Death	28a. Date of Injury	ER/Outpatient 28b. Time of	3 DOA 28c. Injury Work	4 Nursing Ho	ne 5∐ Residen 28d. Describe how	ce 6 Other (Sp	ecify)
VISION	death. stor: After the funer	atlo	Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury		? ⁄es 2 □ No			
UIVISION I or Attending	after deat Director: In by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specifi		et, factory, office		28f. Location (Stre City or Town,		Rural Route Number,
2 5	rrs after ral Dire									
Hosp	within 24 hours after death.  To the Funeral Director: After th completely filled in by the funeral	edical	29a. Certifier 1 Certifying Physic (Check only one) 2 Medicel Exemine	cien: To the best of my kno r: On the basis of examina	wledge, death tion and/or inv	occurred at the tim estigation, in my op	e, date and place, a inion, death occurr	and due to the cau ed at the time, date	se(s) and manner a e and place, and du	as stated. ue to the cause(s)
0	ithin o the omple	Med	29b. Signature and title of certifier	and manner stated.		29c. License	number	290	I. Date signed (Mor	nth, Day, Year)
o tt			· Cars	~	MD		31464		4/211	
Toth	3 ⊢ ō				1 2	-	- ( ( ) 0			
Toth	3 - 3		30. Name and address of person who com		n 23a) (Type F	Print)		h		
Toth	£ 3		30. Name and address of person who comes address of person who comes and address of person who comes and address of person who comes address of person who comes and address of person who comes and address of person who comes and address of person who comes and address of person who comes and address of person who comes and address of person who comes and address of person who comes and address of person who comes and address of person who comes and address of person who com	pleted cause of death (Item	n 23a) (Type, F	Print)		te 308		wx My 212

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 223 2005 /Medical 4b. City, Town, or Location of Death not institution, give street and number) 4c. County of Death Examiner Ryland If Under 24 Hrs. 8. Date of Birth
Min. Month, Day, 7. Age (In yrs. last birthday 5. Social Secorty Number Birthplace (State or Foreign Country) **Funeral** 10M 20F Months Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 7 is marked other then "neturel", or Items 23e or 28e-f show treumetic event, the Medical Examination unit be rediffed at 10d. Inside City Limits 1 Tes 2 No Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 If Yes, Give 1 ☐ Yes 2 ☐ No Specify: Completed by 4 Divorced 3 Widowed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry if item 27 is marked other then College (1-4or 5+) and Mental Hygiene. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Anna9 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Importent: If item 27 is eny injury or other treu 20b. Place of Disposition (Name of cemetery, cramatory or other) Date 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Lices Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) neumonia Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Be Compieted by Physician/Medical Examiner burial-transit To the Hospitel or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of) P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 Probably 4 d Onknown page 2 should 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Cther: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient Certification: To 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation after death Director: / Could not be determined within 24 hours after der To the Funerel Directo completely filled in by th 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) cause of death (Item 23a) (Type, Print) 30. Name and address of person who completed

32. Registrar's Signature

ORIGINAL

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

			1 - State Amend Item Ragistrar	State of 20b-c pe	f Maryland er fh G84	/ Dep	artmen 75705 rtificat	t of H e <b>tas</b>	ealth a Death	and M	lental Hy	giene Reg. No. () (	)5	13815
	Physici	an	1. Decedent's Name (First, Middle, La								2. Date of Dea Month	ath Day	Year	3. Time of Death
	/Media		MATTHEW BOY								APRIL		2005	11:30A <sup>M</sup>
	Examir	ner	4a. Facility Name (If not institution, gi	ve street and num	n <i>ber)</i>		4b. City,	Town, or	Location of	of Death		4c. Count	y of Death	1
	*		3802 CHATHAM ROA		7 Age (le use le s	e bieb do d		LTIM	ORE If Under	24 Hrs	9 Date of Bird	<u> </u>	O Biat	-1/04
L	Funeral Director		220-20-3728	Sex 1∏XM 2□F	7. Age (In yrs. las 74	Yrs.	Months	Days	Hours	Min.	8. Date of Birt (Month, Day AUGUST	2,1930	9. Birti	nplace (State or Foreign untry) MD
	and **		Usual Residence of Decedent  10a. State 10b. County		10c. City,	Town or Le	ocation							10d. Inside City Limits
	Many!	٥	1470		DAT	m TMO	DE							1 X Yes 2 □ No
	28a-	rect	MD 10e. Street and Number		DAI	LTIMO	10f. Zip	Code				10g. Citizen of	What Cou	untry?
	3a or	Funeral Director	3802 CHATHAM ROA	D					212	15		USA	4	
	death ms 2	Jera	11. Marital Status	12. Was Dece	edent Ever in U.S.	13.	Was Deced	dent of Hi			ecify Yes or No- Rican, etc.)	14. Ra		ican Indian,
9	after or Ite	Ē	1 Never Married 2 X Married	Armed Fo 1 XYes If Yes, Giv			1 ☐ Yes		Specify:	n, Puerto	Hican, etc.)		ck, White	, etc.
93	ral',	l by	3 Widowed 4 Divorced	Year or Da	ates: 1950-5	6	1 1 1 1 1 1 1 1 1	ZLALINO	эрөспу.			Speci	BL	ACK
21215-0036	within 72 hours after death with the Maryland ane than "natural", or Items 23a or 28a-1 show the Medical Examinar must be notified at	Completed	15. Decedent's E (Specify only highest gi	ducation ade completed)		(Give	dent's Usua kind of wo	rk done c	durina mosi	t of worki	ing	16b. Kind of E	Business/I	ndustry
121	vithin ne. han'	щ	Elementary/Secondary (0-12)	Coilege (1	-4or 5+)		DO NOT ii					n on		
	filed v Hygie other t		12 17. Father's Name (First, Middle, Las	t)		POL	ICE O	FFIC		ar's Name	(First, Middle,	BCPI		
anc	ntal hed on the ded on the even	Be	MATTHEW BOYD	•/							ANE ASH			
Maryland	hould by Mani	P	19a. Informant's Name/Relationship	(Type Print)		19h. Maili	na Address	(Street a			al Route Numbe		State Z	in Code)
Ma	d 2 shoth and the and traum		MAXINE BOYD/WIFE	(1),00,11							IMORE,			1215
	is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. I them 27 is marked other than "natural", or frems 23s or 28s-f show then traumatic event, the Medical Example Trust be notified at		20a. Method of Disposition		20b. Plac	ce of Dispe	osition (Nar	ne of		C	Date	20c. Location	- City or T	own, State
Baltimore,	B = 5		1 ☑ Burial 2 ☐ Cremation 3 ☐ 1 ☑ Donation 5 ☐ Other (Spec		State Garr	ison!	matory or o	Vet.	Çem.	4-2	8-2005	Owings	Mil	1s MARYLAND
Ė	permit. Pa Departmer Important any injury once.		21. Signature of Funeral Service Lice		-14.11		2. Name an				-			S F.H., INC.
Ba	Depa Impo any il		James	9 7	norto					OIL				AND 21217
760, (8	Physician and hysician and bural-transit	Examiner	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (	(or as a conseque	nce of):	lu	no	Ca	nCv	ı			Interval Between Onset and Death Months
P.O. Box 6876	The law requires that the death certificate be the has been signed by the attending physic bage 2 should be detached for use as the b	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 □Live b 4 □ Pregn 9 □ Unkno		éath 3[ th 5[	⊒Ectopic pr ⊒ Other (sp	pecify)			Ogo Did N	М	ate of deliveration	Day Year
Ś	res th	by	Part II. Other significant conditions	AA (ta S	eain but not result 1	ing in the t	indenying c	ause give	en in Part I.	•	134.	_	3 ☐ Pro	the cause of death?
oro	requi	eted	1 500	Acl	- C. C						, , , , , , , , , , , , , , , , , , ,	-		NAMES OF THE PARTY OF
Records,	8 8	Completed by	LIVE Y	ne gasti	apy						24a. Was autop perfo	sy	Were aut prior to codeath?	opsy findings available ompletion of cause of
Vital	Physician: this certific ral director,	Be (	25. Was case referred to medical examiner?						100	of Death	(Check only o	ne)		
of V	Physic this ce al dire	70	1 ☐ Yes 2 No	Hospital: 1 🗆 I	npatient 2 El	NOutpatie			4 L NU	rsing Ho	me Resid	lence 6 🗆 Ot	her (Spec	ify)
n	ding Pl		27. Manner of Death  1 Natural 5 ☐ Pending	28a. Date (Mon	of Injury 2 th, Day Year)	8b. Time of Injury		28c. Injury Work			28d. Describe h	now injury occu	rred	
Si	Attending r death. ector: After by the fune	cati	2 Accident investigation	ho -			М		Yes 2 □	No				
Division	or Att	ij	3 ☐ Suicide 6 ☐ Could not determined	286. Place	of Injury - At hom ng, etc. (Specify)	e, farm, st	reet, factory	y, office			28f. Location (S City or Tox		ber or Rui	al Route Number,
	urs al urs al ural D	Ce												
	Hosp 24 ho Fune Fune	Medical Certification;	29a. Certifier 1 Cartifying P (Check only one) 2 Madical Exa	minar: On the ba	best of my knowl asis of examinationer stated.	n and/or in	th occurred westigation	at the time, in my of	ne, date an pinion, dea	ith occurr	and due to the o ed at the time, o	cause(s) and m date and place,	anner as and due	stated. to the cause(s)
	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Med	29b. Signature and title of certifier	ale	) NA	X	290	c. License	number	291		29d. Date signe		
	1541		30. Name and address of person who	completed caus	of death (Item 2	(Type	Print)	1/1/2	A - A	A	- A	A/1- 1	000	2-2005 MD 21215
		ate	31. Date filed (Month, Day, Year)		egistrar's Signatu	re V	V.V.	UVE.	ubru	0 110	(C, - 1)	ALLIN	1010	MI Jacob
	Regist	rar	APR	2 5 2003	Blace	. 1	So	we	,					

		•	Maryland / Dep	artment of Health and rtificate of Death		2005 13816
Physic /Med		1. Decedent's Name (First, Middle, Last)  Marjorie H. Bright			2. Date of Death  Month  Da	ay Year 3. Time of Death 7 2005 4 15 A M
Exam		4a. Facility Name (If not institution, give street and num Union Memorial Hospita		4b. City, Town, or Location of Deat Baltimore		c. County of Death
Funera Directo		206-18-6744 1□M 2內F	7. Age (In yrs. last birthday) 79 Yrs.	If Under 1 Year If Under 24 Hrs Months Days Hours Min.		9. Birthplace (State or Foreign Country) Pennsylvania
Aaryland show	or	Usual Residence of Decedent  10a. State  10b. County  MD	10c. City, Town or L	altimore		10d. Inside City Limits 11☑Yes 2 □ No
with the N Ra or 28a-1	Director	10e. Street and Number 830 W. 40th Street #102		10f. Zip Code 21211	10g. C	itizen of What Country?
and 21215-0036  be filed within 72 hours after death with the Maryland tial hygiene.  ad other then "natural", or Itams 23a or 28a-f show event, tre Medical Exartiner must be nutified at	by Funeral	11. Marital Status  1 □ Never Married 2 ☒ Married  1 □ Widowed 4 □ Divorced  12. Was Dece Armed Fo 1 □ Yes If Yes, Giv Year or Divorced	2 [X] No	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer 1 ☐ Yes 2 ☒ No Specify:	pecify Yes or No- to Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: white
21215-0036 ad within 72 hours aff giene. ar than "natural", or the Modical Exam.	Completed by	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1	(Give	dent's Usual Occupation e kind of work done during most of wo DO NOT use retired)	rking 16b. F	Kind of Business/Industry
trd 2 be filed tal Hygind of other event, I	To Be Co	12   4  17. Father's Name (First, Middle, Last)  Harry Ward Humphreys			me (First, Middle, Maide: Virginia Dar	•
iore, Maryland ges 1 and 2 should be file to of Health and Mental H if item 27 is marked off or other traumatic even		19a. Informant's Name/Relationship (Type, Print) Priscilla Bright/daughte		ng Address (Street and Number or Ri Pennsylvania Aven	ue Brynmawr	, PA 19010
Itimer rtmer rtmer rtmer rlant		20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from  4 Donation 5 Other (Specify)  21 Signature of Fungral Service Licenses	State cemetery, cre	matory or other place)		ocation - City or Town, State
Depa (impo		21. Signature of Funera) Service Licensea Ronal C S Wadle, I	B	2 Name and Address of Facility tate Anatomy Boar altimore, MD 212	01	1timore Street
that the death certificate be executed that the attending physician and detached for use as the buriat-transit	Ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Either the original Cause (Disease or injury that initiated events	or as a consequence of):  or as a consequence of):  or as a consequence of):	ccident		Interval Between Onset and Death 2 445
ords, P.O. Box 68 requires that the death certifica seen signed by the attending phool to be detached for use as the condides of the seen of the condides of the seen of the condides of the condides of the condides of the condides of the condides of the condides of the condides of the condides of the condides of the condides of the condides of the condides of the condides of the condides of the condides of the condides of the condides of the condition of the con	Physician/Med	in the past 12 months?	ant at time of death 5[	□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
cords, P. w requires that been signed b should be deta	b	Part II. Other significant conditions contributing to de	eath but not resulting in the u	underlying cause given in Part I.		use contribute to the cause of death?  No 3 Probably 4 Unknown
Rec The law te has b	Completed				24a. Was an autopsy performed? 1 ☐ Yes 2 2 No	24b. Were autopsy findings available prior to completion of cause of death?  1 □ Yes 2 No
vision of Vital F Attending Physician: The r death. sctor: After this certificate by the funeral director, pag	itlon: To Be	27. Manner of Death 28a. Date	npatient 2 ER/Outpatie of Injury h, Day Year)  28b. Time of Injury	nt 3 DOA Other: 4 Nursing H	ath (Check only one) dome 5 Residence 28d. Describe how inju	
Division safer death.  al Diractor: After de in by the fune	Certification:	3 Suicide 6 Could not be 28e. Place	of Injury - At home, farm, st ng, etc. (Specify)	reet, factory, office	28f. Location (Street a City or Town, Stat	nd Number or Rural Route Number, e)
Division ( To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical (	(Check only 2 Medicel Examiner: On the boone) and mani-	best of my knowledge, dea asis of examination and/or in her stated.	th occurred at the time, date and place exestigation, in my opinion, death occurred	urred at the time, date an	d place, and due to the cause(s)
To 1 To 1	×	29b. Signature and title of certifier  MVN Blancus /		29c, License number  AT 2 \(\frac{138c}{1}\)	16E7 Ap	ate signed (Month, Day, Year)  Vil 17 2005
	1010	30. Name and address of person who completed caus Reuven Grossman  31. Date filed (Month, Day, Year)  22. R	e or geath (Item 23a) (Type 20 C C C C C C C C C C C C C C C C C C	Print) Newsily Parkway	(Saltimer	ne MU 2/3/7
Regis	tate strar	31. Date filed (Month, Day, Year) APR 2 5 2005	va St. Apa	whi !		

		•	State of Maryland / Department of Health and N 1- State Registrar Amend Item 23a per Dr., G8420 Amend State of Department of Health and N	ntal Hygier Reg. i	<b>2</b> .005   138 7
П	Physicia	an	1. Decedent's Name (First, Middle, Last)  6FORGE THEONORE BEACHIIM	2. Date of Death	Day Year 0712 A M
	/Medic Examin		4a. Fecility Name (If not institution, give street and number)  4b. City, Town, or Location of Death	(OT)AIK.)	4c. County of Death
1			HOWARD COUNTY GENERAL HOSP COLUMBIA	Tag. (5)	HOWARD
	Funeral Director		5. Social Security Number 212-03-7552 6. Sex 7. Age (In yrs. last birthday) Yrs. 90 Yrs.  If Under 1 Year   If Under 24 Hrs. Months   Days   Hours   Min.	8. Date of Birth (Month, Day, Yea June 18,	ar) 9. Birthplace (State or Foreign Country) 1914 Maryland
	D.		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
	Maryla f sho	ţō	Maryland Howard Jessup		1 □ Yes 2 □ No
	or 28a	Oirec	10e. Street and Number 10f. Zip Code	10g. (	Citizen of What Country?
	death with the Maryland ims 23a or 28a-f show	Funeral Director	7461 Montevideo Road 20794  11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Sp		U.S.A.
	be filed within 72 hours after death with the Marylan ital Hyglene. Id other than insturel; or Items 23a or 28a-f show other than insturel; or Items 23a or 28a-f show event. The Medical Examinating must be notified at	by Fune	11. Marital Status  1 □ Never Married 2 Ă Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 ② Yes 2 □ No If Yes, Give Year or Dates: WWII	Flican, etc.)	Black, White, etc.  Specify: White
21215-0036	72 ho netur	Completed	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)	king 16b.	Kind of Business/Industry
121	within lene	ompi	Elementary/Secondary (0·12)  College (1·4or 5+) 2 Years  College (1·4or 5+) Bank Examiner		tate of Maryland
	be filed tal Hygid d other event, I	Be C		ne (First, Middle, Maid	en Sumame)
Maryland	2 should be and Mental Is marked o	L L	John E. Beachum  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Ru.	L. Delius	v or Town State Zin Code)
	s 1 and 2 should f Health and Mer item 27 Is marke other treumatic		Alice Beachum / spouse 7461 Montevideo Road	Jessup, M	
3altimore,			20a. Method of Disposition  1 XXurial 2 □ Cremation 3 □ Removal from State  20b. Place of Disposition (Name of cemetery, crematory or other place)		Location - City or Town, State
Itim			'4 Donation 5 Other (Specify) Emmanuel U.M.C. Cem. 4/22		Scaggsville, MD
Ba	permit. Departr Imports eny inji		21. Signature of Funeral Service Licensee  22. Name and Address of Funeral  23. Name and Address of Funeral  31. Talbott Avenue		
	8.		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.		Approximate Interval Between Onset and Death
	Pnysician /Medical	M I	Immediate Cause (Final disease or condition resulting in death)  a	VIECTINA	BLFFEYNG
3	Examiner		Sequentially list conditions, b. PANCREATIC FISTO	JLA.	
S.	led ssit	Examiner	if any, leading to immediate Due to (or as a consequence or): cause. Enter Underlying Cause (Disease or injury		
0	be executed sician and burial-transil		that initiated events resulting in death) Last Due to (or as a consequence of):	0	
8760	ate phys	dical	d. FANCELATIC CAN	AK.	
Box 6	eath certific attending p	ician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy		23d. Date of delivery  Month Day Year
P.O. F	tt the dea by the a tached fa	ysic	1 Yes 2 No 9 Unknown 4 Pregnant at time of death 5 Other (specify) 9 Unknown		,
Vital Records, P.	as the	Completed by Physi	Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacc	o use contribute to the cause of death? 2 No 3 Probably
eco	e law requir has been si je 2 should b	plete	PLEURAL REFEUSION	24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
al B	icien: The l certificate ha		ENTERO ENTANEOUS EISTULA.	performed	death? No 1 ☐ Yes 2 No
	ysicien: is certific director,	o Be	25. Was case referred to medical examiner?  1   Yes   2   No	th (Check only one) ome 5 Residence	6 ☐ Other (Specify)
n of	ding Phys h. After this funeral di	on: T	27. Manner of Death 28a. Date of Injury 28b. Time of Injury Work? 28b. Time of Injury Work?	28d. Describe how in	
Division of	Attendi death. ctor: A y the fu	licati	Accident investigation  3 Suicide 6 Could not be as Place of Injury. At home farm street factors office	28f. Location (Street	and Number or Rural Route Number,
Div	tal or At s after o el Direct	Certification:	4 Homicide determined determined building, etc. (Specify)	City or Town, St	ate)
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur and manner stated.	rred at the time, date a	and place, and due to the cause(s)
	with To t	Σ	29b. Signature and the of certifier Puella MA. 29c. License number D2/706	29d. I	Date signed (Month, Day, Year)
9	H		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  MOHAMMED R. GHEBA 2717 HAMMONS	DSFERRY	KOAD BALT. MD.
*	Sta Regist	ate rar	31. Date filed (Month, Day, Year) APR 2 5 2005  32. Registrar's Signature		

Please Type or Print in Black Indelible Ink.	Ensure All Copies Are Legible.
State of Maryland / Department of H	lealth and Mental Hygiene 🗎 🗎 🧲

		1 - State of Maryl State of Maryl Registrar		artment of H		lental Hygie	Some Williams	13818
Physic	ian	1. Decedent's Name (First, Middle, Last)				2. Date of Death Month	Day Year	3. Time of Death
Physic /Medi		AARON	PAUL		BLUM		1 2005	07:10 AM
Exami	ner	4a. Facility Name (If not institution, give street and number)  Sinai Hospital of Baltin		Baltim	0			/A
Funeral Director		V	yrs. last birthday) 88 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Month, Day, Ye 01/03/19	9. Biri	thplace (State or Foreign puntry) MD
land ow			. City, Town or Lo	ocation				10d. Inside City Limits
Many 1 sh	to	MD BALTIMORE	BALT	IMORE				1 □ Yes 2 No
r 28e	Director	10e. Street and Number		10f. Zip Code		10g.	Citizen of What Co	ountry?
death with the Maryland ms 23a or 28e-f show rmst Le rudified at	i D	16 OLD COURT ROAD APT. #318		21208			U.S.A.	
deat ms 2	Funerai	11. Marital Status 12. Was Decedent Ever Amed Forces?	in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba		ecify Yes or No-	14. Race - Ame	
after or Ite		1 Never Married 2 Married 1 Nover 1 Nover Married 2 Married 1 Nover 1		1 ☐ Yes 2 X No	Specify:	riican, etc.,	Black, Whit	•
urel',	d by	3 ₩ Widowed 4 Divorced Year or Dates:						
be filed within 72 hours after death with the Marylar ital Hygiene. Id other than "naturel", or liems 23a or 28e-f show event, the Medical Event event, the Medical Event event.	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occupa kind of work done o DO NOT use retired	furing most of work	ing 16b	o. Kind of Business	/Industry
withir ane. than	E G	Elementary/Secondary (0-12) College (1-4or 5+)		NER	,		RESTAURA	NT
filed Hygie other	င်	17. Father's Name (First, Middle, Last)	UW	NLK	18. Mother's Nam	e (First, Middle, Mai		
ld be file ental Hy ked oth	o Be	SAMUEL	В	LUM	ROSE	(		RESNICK
s 1 and 2 should be f Health and Mental item 27 is marked other treumetic ev	1-	19a. Informant's Name/Relationship (Type, Print)				al Route Number, Ci	ity or Town, State, a	
교육 ta		SANDRA FELDMAN / NIECE	11 S	LADE AVE.	APT. #	601 BALTIN	MORE, MD	21208
of Hee			b. Place of Dispo			Date 200	. Location - City or	Town, State
permit. Pages 1 a Department of Hes mportant: If item any injury or othe		1 🖾 Burial 2 □ Cremation 3 □ Removal from State A  '4 □ Donation 5 □ Other (Specify)	CHA'TM EC'O	MAH <sup>OT</sup> ATETE NG	04/2	2/2005 BA	ALTIMORE,	MD
permit. Pages Department of I Important: If its any injury or o		21. Signature of Funeral Service Licensee	2	2. Name and Addres	s of Facility SOI	LEVINSON	W & BROS.	. INC.
89889		Kolol dun	8	900 REIST		ROAD - PI		
		23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.	death. Do not en	ter the mode of dying	g, such as cardiac	or respiratory arrest,		Approximate Interval Between
Pnysician		Immediate Cause (Final disease or condition	ation	pneum	onia			Onset and Death
/Medical Examiner		resulting in death)  Due to (or s a cor	sequence of):		ST INTERPOLITICS			
	-	Sequentially list conditions, if any, leading to immediate Due to (or as a con	sequence of):					- Question of a
ted rsit	nin	cause. Enter Underlying Cause (Disease or injury	1304001100 01).					
xecu and	Examiner	that initiated events c	sequence of):					
death certificate be executed e attending physician and id for use as the burial-transit	<u>-</u>	d						
ificate g phy as the	edica	- U						
eath certific attending p	M/CI	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of predictions of predictions and the prediction of the pred		Testania aragnanay			23d. Date of del	livery
death cer le attendir ed for use	Physician/M	1 Yes 2 No		□Ectopic pregnancy □ Other (specify)			Month	Day Year
at the by the	hys	9 Unknown						
The law requires that the de tte has been signed by the page 2 should be detached	by	Part II. Other significant conditions contributing to death but not	t resulting in the u	inderlying cause give	en in Part I.			the cause of death?
equir	ted					1 L Yes	2 No 3 Pr	obably 4 <b>20</b> Unknown
he law requires t has been signe ge 2 should be o	ompieted					24a. Was an autopsy	prior to	topsy findings available completion of cause of
	Con					performed 1 ☐ Yes 2 ☑		2 No
ysician; ] is certificat director, p	Be	25. Was case referred to medical examiner?		Other		h (Check only one)		
S 5	2		2 ER/Outpatie		4   Naising Ho	me 5 Residence		cify)
fter fter	ion	27. Manner of Death 1 ★Natural 5 Pending 28a. Date of Injury (Month, Day Yea	r) 28b. Time o	Work	rat (? Yes 2 □ No	28d. Describe how i	njury occurred	
Attending r death. ector: After by the funer	icat	2 Accident investigation 3 Suicide 6 Could not be 28e. Place of Injury -	At home farm st		163 2 110	28f. Location (Stree	t and Number or Ri	iral Route Number
or Attending after death. Director: Afte	Certification;	4 Homicide determined building, etc. (Sp.	ecify)	icet, lactory, office		City or Town, S		rar riosis rustisor,
spite ours illex	edicai Co	29a. Certifier  (Check only 2 ☐ Medical Exeminer: On the basis of example of the basis of example of the basis of example of the basis of example of the basis of example of the basis of example of the basis of example of the basis of example of the basis of example of the basis of example of the basis of example of the basis of example of the basis of t						
To the Hos within 24 h To the Fur completely	Medi	one) and manner stated.		29c. License			Date signed (Monta	
To To cor		29b. Signature and title of certifier  K. A. Zamun, M. P.			S-000		PML 21,	
6			(Itam 00-) ~	51.0			1 - 21,	
5		30. Name and address of person who completed cause of death  KAZI A. ZAMAN , SINA	(ILEM 23a) (Type,	TAL OF	BALTIM	DRE		
St	ate							
Regist		APR 2 5 2005	1º Con	Me .				

		1 - For State Registrer	State of Maryland /		lealth and M	fental Hyg	Reg. No. 2005	1381
Physic	ian	Decedent's Name (First, Middle, Last     ESTHER	)	DDATMA	A.	Date of Dea     Month	Day Year	3. Time of Death
/Med Exami		4a. Facility Name (If not institution, give	street and number)	BROTMA 4b. City. Town, o	r Location of Death	APRIL	21 2005 4c. County of Death	10:20 A <sup>M</sup>
Exami	ilei	MANOR CARE - RUXT		BALTIM			BALTIMO	
Funeral Director		210-40-7937	7. Age ( <i>ln yrs. last l</i>	birthday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day 01/16/1	9. Birth	nplace (State or Foreign untry) MD
/land		Usual Residence of Decedent  10a. State 10b. County	10c. City, To	wn or Location				10d. Inside City Limits
e Man a-fah	ctor	MD BALTIM	ORE TIM	MUINOM				1 □ Yes 2 <b>Y</b> □ No
with th	Funeral Director	10e. Street and Number	т	10f. Zip Code		1	10g. Citizen of What Cor	
leath v	erai	7 BEECH TREE COUR	12. Was Decedent Ever in U.S.	21093		acify Yes or No.	U.S.A.	
be filed within 72 hours after death with the Maryland stal Hygiene.  Identified a confermation of tems 23a or 28a-f ahow avent, its Madical Examine institution in the institution of t	by	1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	13. Was Decedent of H If Yes, specify Cuba 1 Yes 2 No	an, Mexican, Puerto Specify:	Rican, etc.)		
vithin 72 ho ne. han "natur Manical	Completed	15. Decedent's Ed. (Specify only highest grad Elementary/Secondary (0-12)	e completed)  College (1-4or 5+)	ia. Decedent's Usual Occup (Give kind of work done life. DO NOT use retired	during most of work	ing	16b. Kind of Business/I	ndustry
		12 17. Father's Name (First, Middle, Last)		HOMEMAKER	18. Mother's Name	e (First, Middle,	OWN HOME  Maiden Sumame)	
thould be id Mental markad o matic ave	To Be	DAVID	COH	HEN	RACHEL	,		ENDLIN
2 sh and is m		19a. Informant's Name/Relationship (T)		9b. Mailing Address (Street			r, City or Town, State, Z	
t an Heal Bm 2 thar		JERROLD BROTMAN / 20a. Method of Disposition		7 BEECH TREE			MD 21093 20c. Location - City or 1	Town State
0 0		1 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify)	IOITIO VALITIOITI STATO	of Disposition (Name of tery, crematory or other plac JK AMUNO CONG	l l	2/2005	BALTIMORE.	
nit. artm orta inju		21. Signature of Funeral Service Licens		22. Name and Addre	The second second		ON & BROS.,	
Dep Imp any		23a. Part1. Enter the disease, or comp	hour	8900 REIST	ERSTOWN R	0AD - P	IKESVILLE.	MD 21208 Approximate
death certificate be executed  e attending physician and of or use as the burial-transit	icai Examiner	disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last	Due to (or as a consequence).	e of): e of):	ive.	)		
	Physician/Medicai	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	3c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal dea 4 □ Pregnant at time of death 9 □ Unknown	th 3 □Ectopic pregnancy 5 □ Other (specify) _			23d. Date of delin Month	very Day Year
g g	by Pł	Part II. Other significant conditions co.	ntributing to death but not resulting	in the underlying cause give	en in Part I.		bacco use contribute to	1
w require been si should b	eted				· · · · · ·		es 2 No 3 Pro	
The larate has	e Completed	25. Was case referred to medical					prior to co death? 1 Yes	opsy findings available ompletion of cause of
S S	0 B	examiner?	lospital: 1   Inpatient 2   ER/0	Outpatient 3 DOA Other	26. Place of Death er: 4 Hirsing Hol		ence 6 □Other (Speci	ifv)
Jing After fune	ation; T	27. Mann of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 28b	. Time of 28c. Injury Work			ow injury occurred	-17
Diffe of	Certification;	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home, building, etc. (Specify)	farm, street, factory, office		28f. Location (St City or Town	reet and Number or Rur n, State)	al Route Number,
a Hospital 24 hours a a Funaral letely filled	edicai	29a. Certifier (Check only one)  1 Certifying Phy 2 Medical Exami	sician: To the best of my knowledger: On the basis of examination a and manner stated.	ge, death occurred at the tin and/or investigation, in my o	ne, date and place, a pinion, death occurr	and due to the ca ed at the time, da	ause(s) and manner as a ate and place, and due t	stated. to the cause(s)
To tha I	Me	29b. Signature and title of certifier	MD	29c. License	593.	Ul	9d. Date signed (Month,	Day, Year)
6		30. Name and address of person who co	empleted cause of death (Item 23a	SIEN Brive	Suik	208	-	1021201.
St Regist	ate rar	31. Date filed (Month, Day, Year)	32. Registrar's Signature	Smarke				

amend item/1,8,12711,10,322,74/25 in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Ronald Cooper Physician Month Year /Medical 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE CATONSVILLE CALYN ROAD If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1 □ M 2 0 F 217.50.5030 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits 27 is marked other then "naturel", or items 23e or 28e-f show treumatic event, the Mcdical Examiner must be nutified at 5645 CALYN ROAD 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5645 CALYN ROAD USA by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 KEYes 2 □ No 14. Race - American Indian. 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours atter or nent of Health and Mental Hygiene. .nt: If item 27 is marked other then "naturei", or iter 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify. 3 ☐ Widowed 4 ☐ Divorced AC Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) SPECIAL CLERK VERIZON 12 TH GRADE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) FREDRICK COOPER SR. LILLIAN DAILEY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2: Department of Health ar Importent; if item 27 is eny injury or other treuonce. CHARLES MCFADDEN 5645 CALYN RD. BALTO. MD. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 04.27.05 OWINGS MILLS GARRISON FOREST \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licence VAUGHN C. GREENE FUNERAL SERVICE 5151 BAUD. NATU PIKE BAUD. MD 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Due to (or as a consequence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as Examiner -transit and Due to (or burialattending physician Box 68760 Physician/Medical the as IF FEMALE use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 5 Other (specify) Records, P.O. the detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has autopsy performe rmed? 2 X No 1 Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 ☐ Nursing Home 5 Vesidence 6 ☐ Other (Specify)
t 28d. D ribe how injury occurred ျှ 1 ☐ Yes 2 XNo 1 Inpatient 2 ER/Outpatient 3□ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification; After the Hospitei or Attending Natural Injury 5 Pending atter death. 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EMISQ. GREEN HORKINS 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

	State of Maryland / Department of Health and Mental Hygiene  1 - For State Registrar  Certificate of Death  Reg. No. 0 5   3											
			Decedent's Name (First, Middle, Last)	2	Date of Death Month Day Year  3. Time of Death							
	Physicia /Medic		Augustine L. Carky, Sr.	A	PRIL 22,2005 1610PM							
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death							
			SAINT AGNES HEALTHCARE 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	BALTIMORE  v) if Under 1 Year   If Under 24 Hrs.   8	None  Date of Birth 9. Birthplace (State or Foreign							
	Funeral Director		214 22 6840 125M 2 F 76 Yrs.	Months Days Hours Min.	(Month, Day, Year) Aug 18, 1928 Maryland							
	ם		Usual Residence of Decedent									
	anylan show	_	10a. State 10b. County 110c. City, Town or	Location	10d. Inside City Limits 1 ☐ Yes 2 ☐ No							
	Ba-f	ecto	MD Baltimore Cator	nsville 101. Zip Code	10g. Citizen of What Country?							
	with t	급	4 N. Symington	21228	United States							
	death	Funeral Director		Was Decedent of Hispanic Origin? (Specific Yes, specify Cuban, Mexican, Puerto Rice)								
9	within 72 hours after death with the Maryland jiene. Than "natural", or Items 23s or 28s-f show the Medical Examiner must be rediffied at	/ Fun	Armed Forces?  1 ☐ Never Married 2⊠ Married   Armed Forces?  1 ☐ Yes, Give	If Yes, specify Cuban, Mexican, Puerto Hic 1 ☐ Yes 2 ☑ No Specify:	can, etc.)  Black, White, etc.  Specify:							
8	hours ural',	d by	3 ☐ Widowed 4 ☐ Divorced Year or Dates: 1945—46		White							
7	n 72 n nat	Completed	(Specify only highest grade completed) (Gir	edent's Usual Occupation we kind of work done during most of working . DO NOT use retired)	16b. Kind of Business/Industry							
72	l within iene. r than "	mo	Elementary/Secondary (0-12) College (1-4or 5+)  9 Mari	ine Engineer	City of Baltimore							
ਬੂ	file Hyg ent,	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Name (/	First, Middle, Maiden Surname)							
Maryland 21215-0036	should be nd Mental marked c	70 6	Harry Carky	Rose DeRos								
Jar	2 shoul and Me Is mark raumati				Route Number, City or Town, State, Zip Code)							
	s 1 and 2 should f Health and Mer flem 27 is marke other traumatic		20a Method of Disposition 20b. Place of Dis	position (Name of Dat	ille, MD 21228 te 20c. Location - City or Town, State							
altimore,	0 0		Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, co	inmatory or other place) -hedral Cem 4-27-	2005 Baltimore MD							
altir	permit. Pag Department Important: I any injury o		New Cathedral Cem.   4-27-2005 Baltimore, MD  21. Signature of Funeral Service Licensee M01044   22. Name and Address of Facility Harry H. Witzke's Family FH Inc.  4112 Old Columbia Pike Ellicott City, MD 21043									
m	Depa Impo any i											
	Physician		23a. Part1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac or r	respiratory arrest, Approximate Interval Between Onset and Death							
			Immediate Cause (Final disease or condition a. CARDIO PULMONARY ARREST. 8 hrs.									
1	/Medical Examiner	Due to (or as a consequence of):										
		-	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):									
1	d d ansit	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events									
ó	cate be executed physician and the burial-transit		resulting in death) Last Due to (or as a consequence of):									
8760,		dlcal	d									
9		0	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of delivery							
Вох	The law requires that the death certifi ste has been signed by the attending page 2 should be detached for use as	Physiclan/M	in the past 12 months?	B Ectopic pregnancy Dother (specify)	Month Day Year							
0	that the de led by the detached	hysi	1 Yes 2 No 9 Unknown									
S,	es that igned b	by P	Part II, Other significant conditions contributing to death but not resulting in the	* = =	23a. Did tobacco use contribute to the cause of death?							
ord	w require been sig should b	ted		EASE	1 Yes 2 No 3 Probably Winknown							
Records,	has be	Completed	ISCHEMIC CARDIOMYOP	ATHY	24a. Was an autopsy findings available prior to completion of cause of							
<u>~</u>		Con			performed? death? 1 Yes 2 No 1 Yes 2 No							
Vital	Phyeiclan: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	26. Place of Death (								
of		1: To	1 Yes 2 No 1 Inpatient 2 EH/Outpat  27 Manger of Death 28a. Date of Injury 28b. Time	ient 3 DOX 4 Nursing Home	e 5 Residence 6 Other (Specify)  d. Describe how injury occurred							
on	nding Pt ith. : After the funeral	tlor	Matural 5 ☐ Pending (Month, Day Year) Injur 2 ☐ Accident investigation	Work? M 1 ☐ Yes 2 ☐ No								
Division	l or Attendil after death. Director: A I in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 4 ☐ Homicide 28e. Place of injury - At home, farm, building, etc. (Specify)	street, factory, office 28	of. Location (Street and Number or Rural Route Number, City or Town, State)							
Ö	ital or rs after al Dir	Cert										
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune	edical	29a. Certifier (Check only one)  2 Medical Examiner: On the basis of examination and/or and manner stated.									
	omple	Med	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)							
	F > F 0		Dauhan, M.D.	P 18623	APRIL, 22, 2005							
			30. Name and address of person who completed cause of death (Item 23a) (Typ	e Print)								
	P		CHANDANA CHAUHAN, 900 CATO	DN AVENUE, BALT	1 MOKE, 11 1 2 1 229							
	Sta Regist		31. Date filed (Month APR 25 2005 32. Algistrar's Signature	port								

CARKY, AUGUSTINE

			1100	Sta								ental Hy		U U E	-	13822
		1	For Stete Registrar				-	rtificate					- C	UU	J	10022
Phy	sicia	'n	1. Decedent's Name (First, Middle									2. Date of De	ath Day	Ye	ar	3. Time of Death
/M	edica	al .	David Clack			1		4h Cib. To		onation o	4 Dooth	HERL	15	,200	25	Jough
Exa	mine	er	4a. Facility Name (If not institution	give street a	na number), v 0	207-	tal	4b. City, To	5 M		Death	Hu	40. 0	Jounty of L	eatn	
Fune	ral		5. Social Security Number	6. Sex	7. Age	e (In yrs. la	st birthday)	If Under 1		If Under 2	24 Hrs.	8. Date of Bir	th Voort	9.	Birthpla	ace (State or Foreign
Direc	_		229-86-8187	1 <b>∑</b> M 2[	] F	43	Yrs.	Months [	Days	Hours	Min.	May 23	, 196	1 V	irg	inia
pug *		}	Usual Residence of Decedent  10a. State 10b. County			10c. City,	, Town or Lo	cation							10	d. Inside City Limits
Manyli f sho	20	ρ	MD			В	altimo	ore								1¶Yes 2□No
n the	100	rec	10e. Street and Number					10f. Zip C	ode				10g. Citiz	en of Wha	t Count	ry?
th with	181 0	a D	2527 Brookfiel	d Aven	ue #3				2121	7				USA		
ar dea	No.	Funeral Director	11. Marital Status	Am	s Decedent I red Forces?		5. 13.	Was Deceder If Yes, specify	nt of His y Cuban	panic Orig , Mexican	gin? (Spe , Puerto I	cify Yes or No Rican, etc.)	)- 1			
rs afte	Malon	by F	1 Never Married 2 Married 1 Yes 2 Married 1 Yes, Give 14 Divorced Year or Dates:			No 1 ☐ Yes 2 █ No Specify:							Specify: black			
77 hours after death with the Marylan 172 hours after death with the Marylan 178 hours 136 or 286-1 show	lear a		15. Decedent's Education 1 (Specify only highest grade completed)				16a. Dece	dent's Usual (	Occupat	tion	of working	20	16b. Kin	d of Busin	ess/Ind	ustry
ithin 7.	a Mig	Completed	Elementary/Secondary (0-12) College (1-4or 5+)					kind of work DO NOT use	retired)	many moon	0, 110110,	·9	Reg. No.  Sath Day Year   3. Time of Death   15 2005   1500 M   4c. County of Death   1500 M   4c. County of Death   10d. Inside City Limits   12 Yes 2 \  No   10g. Citizen of What Country?   USA   14. Race - American Indian, Black, White, etc.   Specify:   black   16b. Kind of Business/Industry   Construction   Maiden Sumame)   2ams   2er, City or Town, State, Zip Code)   2oc. Location - City or Town, State   Approximate   Interval Between   Onset and Death   Interval Between   Onset and Death   Interval Between   Onset and Death   Interval Between   Onset and			
iled w Hygier ther th			1 1. Father's Name (First, Middle,	asti	0		La	borer		18. Mothe	r's Name	(First, Middle			ctic	n
should be filed within 72 hours after death with the Maryland nd Mental Hygiene.  marked other then "neturel", or Items 23s or 28e-f show	6 6 6	To Be	Willie M. Cl													
shoul and Me	neur neur	F	19a. Informant's Name/Relationsh	nip (Type, Pri	nt)		19b. Mailir	ng Address (5	Street ar	nd Numbe	r or Rura	l Route Numb	er, City or	Town, Sta	te, Zip	Code)
and 2 alth a	er tre		Janice Clack/sp	ouse			402	West C	Grac	e Str	reet	#1 Ric	hmond	l, VA	232	20
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  Interpreted: If Item 27 ie marked other then "neturel", or Items 23s or 28e-1 show	L OIL		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	3 □Remova	from State	20b. Pla	ace of Dispo metery, crer	sition (Name matory or othe	of er place	,	D	ate	20c. Loc	ation - City	or Tov	vn, State
. Pag tment tent:	dinux		`4 ☐ Donation 5 🗓 Other (S)	ecify) in	state					1						
Depare	any ir		21. Sign thur I Funeral Service	wald.	Dir	ector							Ba1	timor	e S	treet
			23a. Part i Enter the disease, or	complications	that caused	the death		altimo					rrest,			Approximate
Physic	ian	n 1	shock, or heart failure. List Immediate Cause (Final	only one caus	e on each lin	ne.										Onset and Death
/Medi	cal		disease or condition resulting in death)	a.	o (or as	a consequ	ence of):	A	0		. 0					
Examii	ner		Sequentially list conditions,	ALC	QUIPS	di	nmu	nodet	HICH	ency	15	ynar	ome			
pe :	)SI	nine	ri any, leading to immediate Due to (or as a consequence of).  cause. Enter Underlying  Cause (Disease or injury						0							
be executed ician and	al-tra	Examiner	that initiated events resulting in death) Last	C	ue to (or as	a consequ	ence of):									
w requires that the death certificate be executed been signed by the attending physician and	e Duri	call	d													
ortifica ing ph	a as th	Physiclan/Medi	IF FEMALE:						-							
ath cer	or use	lan/	23b. Was decedent pregnant in the past 12 months?	10	es, outcome Live birth	2 Fetal	death 3	Ectopic preg					2:			•
the de	ched	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at time of death 5 ☐ Other (specify)9 ☐ Unknown												
that shed by	e deta	by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did t							obacco use contribute to the cause of death?						
requires t	o pin									Yes 2	s 2 No 3 Probably 4 Nonknown					
law re as be	2 sho	ompleted										24a. Was	psy	prior to completion of cause of		
The The	bage	Con										perfo	2 No			2□ No
VICAL vicien: T	rector	Be	25. Was case referred to medical examiner?	Hospita	1:							(Check only o				
2 ff sit	aral di	1: To	1 ☐ Yes 2 ② No 27. Man or of Death		1 Mnpatie Date of Inju (Month, Da		ER/Outpatier 28b. Time o		c. Injury Work				Residence 6 Other (Specify) cribe how injury occurred			
VISION Attending ar death. rector: Afte	e tune	Certification:	1 Natural 5 ☐ Pendin 2 ☐ Accident investig	9	(Month, Da	y Year)	Injury	м		? es 2 □ !	No					
r Atta	by th	tific	3 Suicide 6 Could in determined		Place of Inj	ury - At hor	me, farm, sti	reet, factory,	office		2			Number o	r Rural	Route Number,
urs aft	lled in															
Hosp 24 hol	ately fi	edical		Everniner: O	the hasis of	f examinat	ion and/or in	vestigation in	n my oni	inion deat	th occurre	ad at the time	date and i	place and		
To the Hospitel or Attending Physicien: The law requires that the death certificate within 24 hours after death.  To the Funerel Director: After this certificate has been signed by the attending physicians.	dwoo	Me	29b. Signature and title or certifie					29c. l	License	number	nov		29d. Date	signed (M	onth, D	Pay, Year)
			Sheeze	ka .	-md				89	133	58		4/1	15/0	25	
(1)	/		30. Name and address of person	who complete	ed cause of d	leath (Item	23a) (Type,	Print)	10	1 1	2000	ocal	1/2	507	tas	2
			31. Date filed (Month, Day, Year)	Rd2e1	32. Registr	ar's Signat	70 1/	wyi	une	0	70/1	100	140	7.		
Re	Sta gistr	- 11	APR 2 5 2	005	Enter.	16	And	as of								

			For State Registrar	State of M	aryland / [		nent of H		Mental Hy	giene Reg. No	F. 1=0	
	Physici /Medic		1. Decedent's Name (First, Middle, SARAH	DAVIS	>				2. Date of De Month	21, 2	005 2.	mb of Death 3
	Examin	er	4a. Facility Name (If not institution, BON SECOL	irs Ho	SPITA	1	BAC	Location of Dea	ORE	4c. County		
ŀ	Funeral Director		5. Social Security Number 219-50-2068 Usual Residence of Decedent	. Sex 7. Ag 1 □ M 2 <b>XX</b> F	e (In yrs. last bii		Inder 1 Year Inths Days	Hours Mir			9. Birthplace (S Country) South Car	
	Maryland a-f ehow iified at	10a. State 10b. County 10c. City, Town or Location  MD NA Baltimore								10d. Inside City Limits 1 XXYes 2 □ No		
	with the	Director	10e. Street and Number			11	Of. Zip Code			10g. Citizen of		
	eath vs 234	erai	1814 W. Saratoga Str	12. Was Decedent	Ever in U.S.	13 Was	21223	ispanic Origin?	Specify Yes or No		JSA ce - American India	an
920	d within 72 hours after death with the Maryland Jiene. I them "natural", or Hems 23s or 28s-f ehow The Macical Examiner must be natified at	by Funeral	1 ☐ Never Married 2 ☐ Marrie 3 🛣 Widowed 4 ☐ Divorced	Armed Forces?			s, specify Cuba	Specify:	Specify Yes or No into Rican, etc.)	Bla Specif	ck, White, etc.	ω ,
ίς.	within 72 ho ene. than "natur he wedical	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)		16a.	(Give kind life. DO N	IOT use retired	during most of w	orking		usiness/Industry	
12	a filed will Hygier other the		10 17. Father's Name (First, Middle, La	ect)		Hous	ewife	18 Mother's N	ame (First, Middle		Omestic	
and	0 to 0	To Be	Robert Caldwell					Mary Knoz		, walden ouman	114)	
Maryland	s 1 and 2 should be f Health and Mental item 27 is marked other traumatic ev	<b> -</b> -	19a. Informant's Name/Relationshi		196	. Mailing Ad	Idress (Street a		Rural Route Numb	er, City or Town,	State, Zip Code)	
	12 th		Lucille Davis/ Da	ughter					Baltimore,			
Baltimore,	Pages 1 a nent of Hea int: If item iry or othe		20a. Method of Disposition 12 Burial 2 ☐ Cremation 3		1		Name of y or other plac	1	Date		City or Town, Sta	ite
튶	교든문을 .		*4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service Li		ратспиот	the second second	me and Addres	etery 04-2 ss of Facility	25-05	Baltimo	re, MD	
ä	permi Depar Impo any ir once.		1 Ann			Wyli	e Funera:	1 Home P.A	A. 638N.Gil	mor St. B	alto,MD 21	217
	Pnysician /Medical Examiner	Examiner	23a. Raff. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Approximate Interval Batweer Onset and Deat  Approximate Interval Batw									al Between and Death
68760,	death certificate be executed e attending physician and of for use as the buriat-transit	resulting in death) Last  Due to (or as a consequence of):  d.										<u>-</u>
.O. Box	that the death certifice ed by the attending pt detached for use as t	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal death		ppic pregnancy er (specify)				te of delivery onth Day	Year
rds, P.	law requires that the as been signed by th 2 should be detache	by	Part II. Other significant conditions contributing to dealir but not resulting in the underlying cause given in Part I.							tobacco use contribute to the cause of death?  Yes 2 No 3 Probably 4 Onknown		
Vital Records,	The ate h	Completed							24a. Was autor perfo 1 - Yes	osy rmed?	Were autopsy find prior to completion death? 1 🗆 Yes 2 🗀 No	of cause of
Vita	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:	-5550		Othe		eath (Check only o			
of	g Phys er this ieral di	n: To	1 Yes 2 No 27. Manner of Death	28a. Date of Inju	ry 28b.	Time of	DOA 28c. Injury	4 🗆 Nursing	Home 5 Resident	dence 6 Oth now injury occur		
ion	토목글	atio	1 ☑Natural 5 ☐ Pending (Month, Day Year) Injury Work? 2 ☐ Accident investigation M 1 ☐ Yes 2 ☐ No									
Division		Certification:	3 Suicide 4 Homicide  6 Could not be determined  28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify)  28f. Location (Street and Number or Rural Route Number of State)								Number,	
	To the Hospital or within 24 hours after to the Funeral Dir completely filled in	Medical	(Check only 2 Medical E.	Physician: To the best caminer: On the basis of and manner st	f examination an		gation, in my of	oinion, death occ	curred at the time,	date and place,	and due to the cat	
)	To To com	~	29b. Signature and title of certifier	R. Cr	nzi	n.0	29c. License			_	d (Month, Day, Ye	
1	.\		KositA 1	completed cause of c	12	(Type, Print	) /	BONS	S S S C C C C C	irs t	fospi,	TAL
	Sta Registr		31. Date filed (Month, Day, Year)	32. Regist	ar's Signature	M	Lorde	0				

CLAH	DECKER		For Unpend Item 23a&27 per					_	13824
			1. Decedent's Name (First, Middle, Last)				2. Date of Death Month	Day Yea	3. Time of Death
	Physici /Medio		Selah Hope Decker				APRIL 18		1833 P <sup>M</sup>
	Examir		4a. Facility Name (If not institution, give street and number)  JOHNS HOPKINS HOSPITAL		4b. City, Town, or BALTIM	Location of Death		4c. County of D	eath
20	Funeral Director		5. Social Security Number 6. Sex 7. Age 1 ☐ M 2 □ F 7. Usual Residence of Decedent	e (In yrs. last birt	hday) If Under 1 Year Months Days Yrs. 8	Hours Min.	8. Date of Birth (Month, Day, Ye April 10,		Birthplace (State or Foreign Country) aryland
' /	land		10a. State 10b. County	10c. City, Town	or Location				10d. Inside City Limits
	Mary f sh	ţ	Maryland Howard	Syk	esville				1 ☐ Yes 2 ☑ No
	r 28a	Director	10e. Street and Number		10f. Zip Code		10g.	Citizen of What	Country?
	23a o		799 Sykesville Road		21784		U	SA	
	ems er m	Funeral	11. Marital Status 12. Was Decedent 8 Amed Forces?	Ever in U.S.	13. Was Decedent of His If Yes, specify Cubar	spanic Origin? (Spe n. Mexican, Puerto I	cify Yes or No- Rican, etc.)	14. Race - A Black, W	merican Indian,
21215-0036	be filed within 72 hours after death with the Maryland tal Hygiene. dother than "natural", or terms 23a or 28a-1 show event, the Modical Evertiret must be rectified at	Ď	1 ★Never Married 2 Married 1 Yes 2 ★N If Yes, Give Year or Dates:	lo		Specify:	,	Specify: W	
9	natura	Completed	15. Decedent's Education (Specify only highest grade completed)	16a.	Decedent's Usual Occupa	ition	161	. Kind of Busine	ss/Industry
21	thin 7	nple	Elementary/Secondary (0-12) College (1-4or 5	1+1	(Give kind of work done d life. DO NOT use retired)	)			
2	e filed will Hygien other the	Cor	0 0		infant	40.44.11.1.11		Infant	
and Pure	be fil stal H ad otl even	Be	17. Father's Name (First, Middle, Last)			18. Mother's Name		den Sumame)	
Maryland	nd 2 should be fi lith and Mental H 27 Is marked ot r traumatic evel	ပ	J. Gabriel Decker  19a. Informant's Name/Relationship (Type, Print)	10h	Mailing Address (Street a	Amie Rob		huar Tours State	Tin Code)
Ma	d 2 st th and 7 Is n traun	i i	J.Gabriel Decker		99 Sykesvill				
	The see		20a. Method of Disposition		Disposition (Name of y, crematory or other place			Location - City	
ō	Pages nent of H int: If its iry or of		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	cemeter Crest	y, crematory or other place Lawn Mem. Pa	rk 4/22/		-	
Baltimore,	artır orta inju		' 4 □Donation 5 □Other (Specify)  21. Signature Inveral Service Licensee		22 Name and Address Sterling		1000		
ä	Depa impo any ir		Welle Moi	290	736 Edmon	dson Aven	ue;Catons	sville,	MD 21228
			23a. Part1. Enter the disease, or complications that caused shock, or leart failure. List only one cause on each tin	the death. Do n	not enter the mode of dying	g, such as cardiac o	r respiratory arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition Sudden n						Onset and Death
	/Medical		resulting in death)	a consequence o					
	Examiner		Sequentially list conditions, b						
	pe is	Examiner	cause. Enter Underlying	a consequence o	of):				
	and P-tran	хап	Causs (Disease or injury that initiated events c	a consequence o	of):				
760,	eath certificate be executed attending physician and for use as the burial-transit	calE			,-				
687	phys the		d						1
×	certif ding use as	/Me	IF FEMALE: 23c. If yes, outcome					23d. Date of	delivery
. Box	death e atter ed for u	Physiclan/Med	in the past 12 months?  1 Yes 2 No  9 Unknown	2 Fetal death time of death	3 □Ectopic pregnancy 5 □ Other (specify)			Month	Day Year
P.O.	that the de ed by the detached	hys	9 🗆 Onknown						
Vital Records, F	ign be	by	Part II. Other significant conditions contributing to death but	ut not resulting in	the underlying cause give	n in Part I.	23e. Did tobac 1 ☐ Yes		to the cause of death?  Probably 4 Unknown
Ö	w requir	lete					24a. Was an	24b. Were	autopsy findings available
Re	he law e has age 2 a	Completed					autopsy performed 1 Yes 2	prior death	o completion of cause of ?
ta	ician: Th certificate rector, pag	O	25. Was case referred to medical			26. Place of Death		No 1 X	es 2□ No
Ξ	ysicis is cer direc	OB	examiner? 1 XYes 2 □ No Hospital: 1XI Inpatie	nt 2□ER/Ou	tpatient 3 DOA Othe	-	ne 5 Residence	e 6 □Other (S	pecify)
J of	ing Phys	T:U	27. Manner of Death  1▼ Natural 5 □ Pending (Month, Day	ry 28b. T	ime of 28c. Injury	at 2	8d. Describe how i	njury occurred	
io	utending Physician: The d∈ath. ctur: After this certificate h: y the funeral director, page	atlo	2 Accident investigation			res 2 □ No			
Division	To the Hospital or Attentwithin 24 hours after dealt To the Funeral Director: completely filled in by the	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Inju	ury - At home, fai c. (Specify)	rm, street, factory, office	2	8f. Location (Stree City or Town, S		Rural Route Number,
	ours at		20. Continue of Continue Physician To the best	of my knowledge	death are used at the time	. data and alass	and alve to the corre	-(a) and manned	an state of
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	edical	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of the control of the control one one of the certified Physician: To the best of the control of the certified Physician: To the best of the certified Physician: To the cert	examination and					
	o the o the	Me	29b. Signature and title of certifier		29c. License	number	29d.	Date signed (Mo	onth, Day, Year)
	⊢ ≯ ⊢ ō		in his, m.D		OCME		Apı	il 20,	2005
			30. Name and address of person who completed cause of de	eath (Item 23a) (	Туре, Print) 111 г	Penn Stree	-		
			31. Date filed (Month, Day, Year) 32. Restrict	ar's Signature	1.1.1	GIM DETER	=c Ddltl	more, Ma	ryland 21201
Ka	St Regist	ate rar	APR 2 5 2005		Speck				

			Amend item#19b	se Type or person, State	<b>Print i</b> G847 of Mary	n <b>Black In</b> 9/29/05 land / Dep	<b>delible Ink</b> artment of I	. Ensure A	<b>All Copie</b> Mental H	<b>s Are L</b> ygiene,	egible.	1000
			1 - For State Registrar			Ce	rtificate of	Death		Reg. No.	CUU	13825
			1. Decedent's Name (First, Midd	lle, Last)					2. Date of D	Day	Year	3. Time of Death
	Physici /Medic		Jeff				Doby J	r.	april	14	200	1 531PM
	Examin		4a. Facility Name (If not institution	on, give street and n	umper)		4b. City, Tawn, o	or Location of Dea	th \	4c. C	County of Dea	ath
	Funeral Director		5. Social Security Number 251-24-6844	6. Sex 1	7. Age (In	yrs. last birthday, Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min	(Month, L	lirth Day, Year) LOO	C	rthplace (State or Foreign ountry) SC
	pur *		Usual Residence of Decedent  10a. State 10b. Count		100	c. City, Town or L	ocation					10d. Inside City Limits
	shor	5	-41		100	Baltin						1 ☑ Yes 2 ☐ No
	vith the Maryland t or 28e-f show	ect	MD NA			Daiti	10f. Zip Code			10c Citize	en of What C	••
	23a or	اق		λ			212	15			S.A.	•
	eath w	era	4012 Hayward		cedent Ever	in U.S. 13.	1		Specify Yes or N			erican Indian,
36	72 hours after death with the Maryland neturel; or liems 23a or 28e-1 show liteal Examiner rust be muffled at	by Funeral Director	1 Never Married 2 Ma 3 XWidowed 4 Divorce	rried Armed F	Forces? 2 🔀 No Bive		Was Decedent of Hif Yes, specify Cub 1 ☐ Yes 2X No		to Rican, etc.)		Black, Whi	
8	"neturel",			nt's Education		16a, Dece	dent's Usual Occur	pation		16h Kind	d of Business	
21215-0036	ges 1 and 2 should be filed within 72 hours after der to Heath and Mental Hygiene. If Item 27 is marked other then "neturel", or items or other treumatic event, the Medical Examinar.	Completed		est grade completed College	(1-4or 5+)	(Give	kind of work done DO NOT use retire	during most of wo	rking			.gh School
d 2	filled Hygid the	e Cc	17. Father's Name (First, Middle	, Last)		0.0	HILLOL	18. Morber's Na	mp (First, Midel			.gn beneer
Maryland	Mental Mental arked c	To B	Jeff Doby Sr	•				Rosea I	ce Ha	npton	by	
ary	shound M	-	19a. Informant's Name/Relation			19b. Mail	ng Address (Street					Zip Code)
	nd 2 alth a 27 is		Rose Lee Ham	pton-Day	ughte	r 4012	2 Haywar	d Ave,	Balti	more,	Md	21215
Baltimore,	es 1 and 3 of Health filem 27 r other tr		20a. Method of Disposition		2	0b. Place of Disp			Date		ation - City or	Town, State
E	permit. Pages Department of Importent: If I eny injury or once.		1 🔀 Burial 2 □ Cremation 14 □ Donation 5 □ Other (-				-	1	/23/05	Rand	allst	own, Md
alti	permit. Pag Department Importent: I eny injury c		21. Signature of Funeral Service	Licensee			2. Name and Addre		20,00	Huma	GIIDC	.0 1117 110
Ö	permi Depa impo eny it		e terme	a. 11	Jome	Son 4:	300 Waba	ash Ave	Balt	imore	, Md	21215
	Physician		23a. Part1 Enter the disease, c shock or heart failure. Lis Immediate Cause (Final	t only one cause on	each line.	death. Do not en	ter the mode of dyin	ng, such as cardia	c or respiratory	arrest,		Approximate Interval Between Onset and Death
	/Medical		disease of condition resulting in death)	a	O M au	naequence of):	4 2001	9				40 mgs
В	Examiner			Re	nal	In Stel	la cens					Long stand
		Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	o (or as a co	nsequence of):		q				0
	cuted nd ransil	Examiner	that initiated events	С								
60,	certificate be executer Iding physician and Ise as the burial-trans		resulting in death) Last	Due to	o (or as a co	nsequence of):						
376	ate be nysici he bu	ical		d								
(887	intificating ph	Med	IF FEMALE:									
.O. Box	death e atter d for u	by Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		birth 2 🗍 gnant at time	Fetal death 3	□Ectopic pregnanc □ Other (specify) _	у		23	3d. Date of de Month	livery Day Year
Д	requires that the een signed by th rould be detache	Ph	Part II. Other significant condit	ions contributing to	death but no	at resulting in the I	indertying cause on	ven in Part I	23e. Did	tobacco use	e contribute to	o the cause of death?
Vital Records,	uires tha signed I d be det			<b>3</b>						Yes 2□		robably 4 Onknown
Ö		ompleted							04- 46		0.45 144	Contract to the contract to th
3ec	e ta has	mpl							24a. Wa aut	s an opsy formed?	prior to death?	utopsy findings available completion of cause of
alF	G C	O							1 ☐ Yes		1 🗆 Yes	2 1 1 No
Vit	Physicien: this certific ral director,	Be	25. Was case referred to medic examiner?	Hoopital:			Ott	26. Place of De				
ō	Phys this ral dii	T.	1 Yes 2 No	16		2 ER/Outpatie	IL SELDON	4   Indising i	dome 5 ☐ Res			ecify)
uc	ding After fune	tion	1 ☑Natural 5 ☐ Pend	ing (Mo	e of Injury onth, Day Yea	ar) Injury	Wo	rk? ]Yes 2 □No	204. 2030/104	inow injury	occurred	
isi	Attending r death. sctor: After by the fune	lica	3 Suicide 6 □ Could	l set be	ce of Injury -	At home, farm, st			28f. Location	(Street and	Number or Ri	ural Route Number.
Division	pitel or Al burs after o lerel Direc filled in by	Certification:	4 Homicide deten	mined 200. Flat	ding, etc. (S	pecify)	reet, factory, office		City or T	own, State)		
-	To the Hospitel or Attendwithin 24 hours after deatl To the Funerel Director:	edical Co	29a. Certifier 1 Certify (Check only one) 2 Medica	ing Physician: To the	ne best of my basis of exa	y knowledge, dea mination and/or ir	h occurred at the ti	me, date and place opinion, death occ	e, and due to the urred at the time	e cause(s) a e, date and p	nd manner as place, and due	s stated. e to the cause(s)
	To the Hos within 24 hr To the Fun completely	Mec	29b. Signature and title of certifi		stated.		29c. Licens	se number		29d. Date	signed (Mont	th, Day, Year)
	F 3 F 8		1 DIAC	IAM NA	4		DA	0217	30	al	214	14 2001
	12		20 Name and address of	vvi CV	uso of door	/Item 22a\ /T	Print)	00113		- 7	nun	17 000 5
	5		30. Name and address of parson	Kha.	MAD	5 i in	an Hosp	utal 41	Ba	timen	~1	
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Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Alma C. Donohue 12:00PM 1005 /Medical 4a, Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3a Himore None 8. Date of Birth (Month, Day, Year) Dec 17, 1911 If Under 24 Hrs 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 🔀 F Months Hours 215 30 2875 93 Director Maryland Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Exercitor must be possified at 1 Yes 2 No MD Howard Ellicott City Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9569 Joey Drive 21042 United States Items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 72 hours after 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 ō 1 Tyes 2 No Specify: þ 3 ₩ Widowed 4 Divorced White natural', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 should be filed within 7 th and Mental Hygiene. 7 Is marked othar than "r Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Murphy Alma Webbert 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Itam 27 i 9569 Joey Drive Ellicott City, MD 21042 Rosemary City/Daughter Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of Important: If It any injury or o o 1 □Burial 2 □ Cremation 3 □ Removal from State Lakeview Cemetery 4-26-2005 \* 4 ☐ Donation 5 ☐ Other (Specify) Sykesville, MD 21. Signature of Funeral Service Licensee M01044 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications trat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 1203 00(5 disease or condition resulting in death) /Medical Due to ( as a consequence of): Examiner nonzu-Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine be executed burial-transit Due to (or as a consequence of): physician Physician/Medical use as the the attending IF FEMALE Box 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown ō Month Day Year 4 Pregnant at time of death 5 Other (specify) o. detached 9 Unknown à ۵. signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an SCURT certificate has page 1 Yes 2 No Vital 25. Was case referred to medical director 26. Place of Death (Check only one) examiner' Hospital: 1 Inpatient Cther: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No **ER/Outpatient** 2 1 🗌 Yes 3 DOA this of funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manger of Death 28b. Time of 28d. Describe how injury occurred After t Certification; Division or Attanding 1 Natural 2 Accident Injury 5 Pending death. 1 Tes 2 No investigation Diractor: 6 Could not be determined 3 TSuicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours after To the Funarel Dirac Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Death occurred at the time, date and place, and due to the cause(s) and due to the cause(s). 29a. Certifier cal (Check only one) and manner stated.

State Registrar

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APR 25 2005

10001 31. Date filed (Month, Day, Year)

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lame and address of person who completed cause of death (Item 23a) (Type, Print)

OUNDEU

29b. Signature and title of certifier

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29c. License number

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05 <b>-</b> 27			1 → For State Registrar	State of Mary	land / Dep	artment o	of Health a	and Me	ntal Hyg	g. No.2 (	105	1382
/	nysicia Medic xamin	al	Decedent's Name (First, Middle, Last)     GAILET ROXSAN DA      4a. Facility Name (If not institution, give s			4b. City, Tow	m, or Location o	A	Date of Deat Month PRIL	19, 20	Year 005 ty of Death	3. Time of Death
Fur	neral		ST. AGNES HOSPITA	L	yrs. last birthday) 50 Yrs.	If Under 1 Y	ORE CIT		Date of Birth (Month, Day, 0-7-195		N/A 9. Birthe	olace (State or Foreig LAND
Maryland	liffied at	ctor	Usual Residence of Decedent	100	c. City, Town or Lo						1	0d. Inside City Limit
ath with the	wat be no	Funerai Director	10e. Street and Number 609 N. DUKELAND			10f. Zip Coo	216			Og. Citizen of	A	
of 2 should be filed within 72 hours after death with the Maryland than Mental Hygiene. 27 is marked other than "natural" or Hams 23a or 28a-4 show	instituti, or rems coa or toers snow	र्व	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:		Was Decedent If Yes, specify ( 1 ☐ Yes 2\(\)	of Hispanic Oric Cuban, Mexican No Specify:	gin? (Specit , Puerto Ric	fy Yes or No- can, etc.)		ace - Americ ack, White, ify: BLA	etc.
d within 72 h giene.	IL S Miss	Completed	15. Decedent's Educify only highest grade  [Specify only highest grade  Elementary/Secondary (0-12)  -12-	cation o completed)  College (1-4or 5+)  -0-	(Give	dent's Usual Od kind of work do DO NOT use re EKEEPIN	one during most etired)	of working		16b. Kind of I	Business/Ind SPITAL	
should be filed ind Mental Hygi	treumatic evant,	To Be C	17. Father's Name (First, Middle, Last)  JOHN DAVIS	and Grinds	10h H-11	- Add (CA	EMM	1A THE		1027		
1 and 2 Health a	othar		19a. Informant's Name/Relationship (Ty, GAILET DAVIS (DAU  20a. Method of Disposition	GHTER)	4209 Ob. Place of Dispo	OLD FI	of		BALTIM		IARYLA	ND 21229
permit. Pages Department of I			1 ⊠Burial 2 □ Cremation 3 □ R  '4 □ Donation 5 □ Other (Specify)  21. Signature 1 □ √ all Service Upens	M.	T. ZION	CEMETER	RY 4	y PHII	LIPS F	UNERAL	HOME	ARYLAND , P.A. AND 21217
Physi /Med Exam	dical		23a. Part1. Enter the disease, or complished, of heart failure. List only or Immediate Chuse (Final disease or condition resulting in death)	cations that caused the e cause on each line.  HYPEATEN  Due to (or as a co	ISIVE AT				DIOVAS			Approximate Interval Between Onset and Death
ite be executed	prysician and the burial-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a co								
ath certifi	Se as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 ☑ Unknown	3c. If yes, outcome of pi 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	⊒Ectopic pregn ⊒ Other (s <i>pecif</i> )				1	ate of delive	ory Day Year
equires that	d be de	by	Part II. Other significant conditions cor	tributing to death but no	ot resulting in the u	inderlying cause	e given in Part I.			acco use cor s 2 □ No		ne cause of death? ably 4 ÆUnknow
The	page 2	Completed							24a. Was ar autopsy perform 1 Yes 2	/	prior to cor death?	psy findings availab npletion of cause of 2 No
Attending Physician: r death. actor: After this certific	nueral (	ation; To Be	25. Was case referred to medical examiner?  1 XYes 2 No  27. Manner of Death  1 Natural 5 Pending investigation	ospital: 1 □ Inpatient 28a. Date of Injury (Month, Day Ye	2 ER/Outpatier 28b. Time of Injury	f 28c.	Other	rsing Home	Check only one 5 Reside d. Describe ho	nce 6 □Ot		v)
ital or Attending after death.	led in by the	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - building, etc. (S	At home, farm, st	reet, factory, off	lice	289	f. Location (Str City or Town		ber or Rura	l Route Number,
To the Hospital or within 24 hours after To the Funeral Dira	npletely fil	Medical	(Check only 2 Medical Examinate)	ner: On the best of maner: On the basis of exa and manner stated.	y knowledge, deat mination and/or in	vestigation, in r	my opinion, deat	d place, and th occurred	at the time, da	te and place	, and due to	the cause(s)
with a	000	2	29b. Signature and title of certifier	1		OC	ME			APRIL1		
	C		30. Name and address of person who co  AWA RUB(0  31. Date filed (Month, Day, Year)				1 Penn S	Stree	t Balt	imore	, Mary	land 2120
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Elliott, Tosiah Baltimore, Maryland 21215-0036

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1 - For State Registrar		State of Ma	aryland	-	artment of I <i>rtificate of</i>		nd Me		giene Reg. No. ,	0.0.		
Physici /Medic		1. Decedent's Nam	e (First, Middle, Last,	Josia	h E11:	iott				2. Date of Dea	Z Pay	200		Time of Death
Examir Funeral Director		4a. Facility Name (INOrth) 5. Social Security N 245-16-	4.5	el Hos	pita 6 (In yrs. la	St birthday Yrs.	4b. City, Town, of Clen  If Under 1 Year  Months Days	Bur	nie 4 Hrs. Min.	8. Date of Birti (Month, Day Feb 18,	An.	9. Bi	Pru irthplac country	nde/ e (State or Foreign Carolina
Maryland f show	or	Usual Residence of 10a. State	f Decedent 10b. County	.1.1	10c. City,	Town or L	ocation			10,				Inside City Limits 1 ☑ Yes 2 ☐ No
permit. Pages 1 and 2 should be filed within 72 hours affer death with the Maryland Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene. Important: If fam 27 is marked othar then "natural", or items 23a or 28a-f show any injury or other traumatic avant, It a Madical Examiner must be notified at once.	Funeral Director	10e. Street and Nu	terey Aver	nue		nton	10f. Zip Code 21113				U.S.	en of What C	Country	?
ours atter de ral', or Itams Exeniter m	by	11. Marital Status 1 ☐ Never Marr 3 ☐ Widowed	ied 2⊠ Married	12. Was Decedent Armed Forces? 1 X Yes 2 ☐ I If Yes, Give Year or Dates:	No		Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 ☑ No		in? (Spec Puerto R	ify Yes or No- ican, etc.)	Ì	4. Race - Am Black, Wh Specify: Wh		
within 72 nd lene. 'then "natu	Completed	(Spec Elementary/Seco 12	15. Decedent's Educify only highest gradendary (0-12)	cation e <i>completed)</i> College (1-4or 5	5+)	(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of	of working	g	Unit	of Business ted St Force		•
ould be riled Mental Hygi arked othar atic avant, I	To Be Co		(First, Middle, Last) Elliott			DOI'U		18. Mother		(First, Middle, Muth				
t and 2 snd Health and tam 27 is m			M. Elliot  position		20b. Pla	458 1	ng Address <i>(Street</i> <b>Monterey</b> position <i>(Name of</i>	Avenue		enton,	Mary		2111	13
permit. Pages Department of Important: If i any injury or once.		¹ 4 ☐ Donation	☐ Cremation 3 ☐ F 5 ☐ Other (Specify) uneral Service License		1	land	matory or other pla Veterans 2. Name and Addre Oonaldson	Cem A						Maryland
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Chysician and Medical pe executed to be printed in as the printed in the printed	ledical Examiner	disease or condition resulting in death)  Sequentially list confidency, leading to incause. Enter Under Cause (Disease or that initiated events resulting in death) in the confidency of the con	nditions, nmediate orlying injury	Due to (or as  Due to (or as  Due to (or as		ence of): ence of):	ocutic	Lenk	em	12				
e attendin	hysician/Me	IF FEMALE: 23b. Was deceden in the past 12 1  Yes 2 [ 9  Unknown	months?	3c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal d	leath 3	Ectopic pregnancy Other (specify)	у			23	d. Date of de Month	elivery Day	/ Year
as been signed by th 2 should be detache	eted by Pł	Part II. Other signif	licant co <b>nditions</b> cor	tributing to death b	ut not result	ing in the u	nderlying cause gw	ven in Part I.			bacco use		o the ca	ause of death?
ite h	Comp	0.5 W							_		med? 2 No	24b. Were a prior to death? 1 ☐ Yes	comple	findings available tion of cause of No
ofter this	atlon; To Be	25. Was case refer examiner?  1  Yes 2   27. Manner of Deat  1  Natural  2  Accident	No H	1 Inpatie 28a. Date of Inju (Month, Day	ry 2	R/Outpatier 28b. Time o Injury	f 28c. Injur	ner: 4 ☐ Nurs	ing Home	Check only on 5 ☐ Reside d. Describe ho	ence 6		ecify)	
	al Certification;	3 Suicide 4 Homicide	6 Could not be determined	building, etc	c. (Specify)		eet, factory, office	ne date and		f. Location (Si City or Town	n, State)			
within 24 hours after the Funeral Dir completely filled in	Medical	(Check only one)  29b. Signature and	2 Medical Exemil	ner: On the basis of and manner sta	examination ted.	in and/or in	29c. Licens	e number	occurred	at the time, d	9d. Date	signed (Mont	e to the	cause(s)
77		30 Name and add	of person who co	mpleted cause of place of the TT TT TT TT TT TT TT TT TT TT TT TT TT	eath (Item 2	(Type.	Print)	give, (	Gler	Bur	nie	MD,	21	.061
Sta Registr		e all miss and a	APR 2	2 Sendansus	The state of the s	-								

Division of Vital Records, P.O. Box 68760,

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registral Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** APRIL 22, 2005 4:45 DEBORAH FURNISH /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner UPPER CHESAPEAKE MEDICAL CENTER BELAIR HARFORD If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours Min. Director 403.78.3105 53 NOV 15, 1951 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County ns 23a or 28a-f show 1 Yes 2 No Funeral Director HARFORD BELAIR 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 400 M HARRISON CT. 21014 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. Yes XX No 1 Never Married Married ō Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Be Completed by 3 ☐ Widowed 4 ☐ Divorced Year or Dates:  $\overline{\mathbf{X}}$ WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 SECRETARY STATE GOVT other traumatic event, 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) 2 should be fi and Mental H is marked ot MARVIN SHARFE FRANCES RICE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) STEVEN FURNISH 400 M HARRISON CT. BELAIR, MD 21014 Health am 27 3altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State To 1 Burial 2 Cremation 3 Removal from State ō Department of Important: If any injury or 4 □ Donation 5 □ Other (Specify) FRANKFORT CEMETERY 4.27.2005 FRANKFORT, KY 21. Signal of Funeral Sovice Lic MARYLAND MORTUARY SUPPORT GREGORY FY 426 CRAINHWY SW GLEN BURNIE, MD 21061 MO1148 Approximate
Interval Between
Onset and Death

3 days Enter the disease) or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) SEDTIC SHOCK Physician /Medical Due to (or as a consequence of): Examiner ANASARCA HTION METASTASIS Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Que to for as a consequence of Physician/Medical Examiner CANCER VARIAN Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months 1 ☐ Yes 2 No Month Day Year 4☐ Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 1 Yes 2 No 3 Probably 4 Winknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed 1 🗌 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Natural 5 Pending investigation 1 Yes 2 No 2 Accident 3 🗌 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a To the Funaral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medicai (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 05 94000 141080 hara MO Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 BELAIR Maziony CHURCHVILLE Rd. 1208, MO. 32 Registrar's Signature 31. Date filed (Month, Day, Year) State APR 25 Registrar

L'USIUNY,

				ryland / Depa	artment of Health and Martificate of Death	-	ne 2005	1383
	Dhyoisi	-	Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day Year	3. Time of Death
	Physici /Medio		ALEXANDER FLOURNOY			APRIL 19	2005	7:40 P <sup>M</sup>
	Examir	er	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death	_
	Funeval		7903 TRAPPE ROAD  5. Social Security Number	(In yrs. last birthday)	DUNDALK  If Under 1 Year If Under 24 Hrs.	8. Date of Birth	BALT IMOR	
	Funeral Director		220-03-6827 1X□M 2□F 844 Usual Residence of Decedent	Ven	Months Days Hours Min.	8. Date of Birth (Month, Day, Ye APRIL 23	,1920	lace (State or Foreign http)
	irylan show	_	10a. State 10b. County	10c. City, Town or Lo	ocation		1	Od. Inside City Limits
	Se-1 s	by Funeral Director	MD BALTIMORE	DUNDA				MYes 2 No
	with the	DIE	10e. Street and Number		10f. Zip Code	10g.	Citizen of What Coun	try?
	ns 23	eral	7903 TRAPPE ROAD  11. Marital Status  12. Was Decedent Ev	ver in U.S. 13.	Was Decedent of Hispanic Origin? (Soc	cify Yes or No-	USA 14. Race - Americ	an Indian
G	or Iten	Fun	Armed Forces? 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No		Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White,	
ğ	rel', c		3 X Widowed 4 □ Divorced If Yes, Give Year or Dates:		1 ☐ Yes 2 🔯 No Specify:		Specify: BLA	\CK
21215-0036	within 72 hours after death with the Maryland ene. then "naturel", or Items 23e or 28e-1 show he Medical Examinat must be notified at	Completed	<ol> <li>Decedent's Education (Specify only highest grade completed)</li> </ol>	(Give	dent's Usual Occupation kind of work done during most of working	ng 16b	. Kind of Business/Inc	Justry
7	within ene. then	dui	Elementary/Secondary (0-12) College (1-4or 5+	)	DO NOT use retired)			
0	filed Hygir other		17. Father's Name (First, Middle, Last)	ru	REMAN 18. Mother's Name	(First, Middle, Maid	ETHLEHEM S den Sumame)	TEEL
<u>la</u> n	lid be lentati rked ric ev	To Be	WILLIAM FLOURNOY		JANIE	WATKINS		
Maryland	should land land land land		19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Street and Number or Rura	l Route Number, Ci	ty or Town, State, Zip	Code)
	and 2 ealth m 27 I		ANDREA MITCHELL/DAUGHTER		16 ATEN ST. FORT W			
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mentat Hygiene. Important: If item 27 is marked other then "naturel", or Items 23e or 28e-1 show way injury or other traumatic event, the Medical Examinet must be notified at ance.		20a. Method of Disposition 1   ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State	20b. Place of Dispo	natory or other place)		. Location - City or To	wn, State
Ë	t. Pa rtmen rtant: rjury		'4 □Donation 5 □Other (Specify)		TITLE LIMITS TICS	-2005 <sub>LA</sub>	UREL, MARY	/LAND
Bal	Departing Department of the police of the po		21. Signature of Funeral Service Licensee		2. Name and Address of FacilityJAME 701-31 LAURENS ST.		ON & SONS ORE, MARYLA	
	Medical Examiner  Weicien and price burial-fransit	Examiner	resulting in death)  Due to (or as a Sequentially list conditions, if any, leading to immediate Cause Elect Underlying Cause (Disease or injury that initiated events  Due to (or as a Cause (Disease or injury that initiated events	consequence of):	Black Cane		,	Approximate Interval Between Onset and Death
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<u>Р</u> О	the di ny the ached	ysle	1 Yes 2 No 9 Unknown 9 Unknown	110 01 dodin	- Cition (Specify)			
Ś	quires that the death n signed by the atte uld be detached for		Part II. Other significant conditions contributing to death but	not resulting in the u	nderlying cause given in Part I.	23e. Did tobacc	co use contribute to the	e cause of death? ably 4 Unknown
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Vital	ysician: The lis certificate he director, page	Bec	25. Was case referred to medical examiner?		26. Place of Death	(Check only one)		
Division of V	를 들 들	2	Hospital:	2 ER/Outpatien 28b. Time of Injury		ne 5 Residence 28d. Describe how in		)
Divis	To the Hospitel or Attending within 24 hours after death.  To the Funerel Director: After completely filled in by the fune	Certification;	2 □ Cuiside 6 □ Could not be	/ - At home, farm, str (Specify)	eet, factory, office	8f. Location (Street City or Town, St	and Number or Rural ate)	Route Number,
	he Hospitel in 24 hours a he Funerel f pletely filled	edical	29a. Certifier (Check only one)  1 Certifying Physicien: To the best of 2 Medicel Exeminer: On the basis of e and manner state	xamination and/or inv	n occurred at the time, date and place, a vestigation, in my opinion, death occurre	and due to the cause ad at the time, date a	e(s) and manner as sta and place, and due to	ited. the cause(s)
	To the within 2 To the complet	Ž	29b. Signature and title of certifier	0	29c. License number		Date signed (Month, D	-
)	1		m. furtell sloff	Myrenia	m D19714	14/	21/05	
	4		30. Name and address of personywho completed cause of dee M1448121 VRT211 J7	th (Itym 23a) (Type,	9 19714 9940 EATZEL	Ave BAZ	TIME FR MG	12224
	Sta Registr		31. Date filed (Month, Day, Year)  APR 2 5 2005	s Signature	Specie		•	

			1 - For State Registrar	State of Ma	aryland / Depa <i>Cei</i>	artment of H			ilene	05 1300
	Physic /Medi	cal	Decedent's Name (First, Middle, Las ALBERT      ALBERT  4a. Facility Name (If not institution, give	C. FC	OWLER	4b. City, Town, or	Logation of De	2. Date of Dea Month	Day 19 2	Year 17:30 M.
	Exami	ner	North Arunde  5. Social Security Number 6. S	1 Hospital	e (In yrs. last birthday)		Burnie			ne Arundel
ŀ	Funeral Director		216-30-7528 Usual Residence of Decedent	ØM 2□F	70 Yrs.	Months Days		in. Oct.28,	1934	9. Birthplace (State or Foreign Country) Maryland
	ne Marylan 8e-f show	Director	Maryland Anne Ar	undel	10c. City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	ath with the 23e or 2 institle in		10e. Street and Number 7882 Americana Ci	rcle Apt.	101	10f. Zip Code 21060	0	1	0g. Citizen of W U.S.	
9036	be filed within 72 hours after death with the Maryland hal Hygiene. d other than "natural", or items 23e or 28e-f show event, the Medical Evaminat must be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:	lo l	Was Decedent of Hi f Yes, specify Cuba 1 ☐ Yes 2 ☑ No	spanic Origin? n, Mexican, Pu Specify:	(Specify Yes or No- erto Rican, etc.)		- American Indian, k, White, etc. White
Maryland 21215-0036	d within 72 h giene. ir than "natu the Medical	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	lucation de completed) College (1-4or 5-	(Give life. L	dent's Usual Occupa kind of work done of DO NOT use retired,	during most of v	working	16b. Kind of Bus	Technologies
yland;	ould be filed a Mental Hygis tarked other i	To Be C		owler			The1		Maiden Sumame Orman	)
	ges 1 and 2 should t of Health and Men If item 27 is marke or other traumatic			<sup>Гурө, Print)</sup> (Daughter)	209 D	evon Cour	ct, Lin	Rural Route Number thicum, Ma		
Baltimore,	mit. Pages 1 partment of H cortant: If ital injury or oth		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specify		20b. Place of Dispo- cemetery, cren Bayview C		04-	01.05		e, Maryland
Balt	permit. Pag Department Important: It eny injury o		21. Signature of Fundral Service Lieth	Commo	/// Mg	Name and Addres Cully-Pol O4 Mounta	lyniak ain Roa	Funeral Ho d, Pasader	ome P.A. Na, Marý	land 21122
	Pnysician /Medical		23a Part 1. Enter the disease, or community shock, or heart failure. List only disease or condition resulting in death)	a Myoc	antial i	er the mode of dying	g, such as card	iac or respiratory arre	est,	Approximate Interval Between Onset and Death
	Examiner	je.	Sequentially list conditions,	b. Christian as a	consequence of):	el faile	Are			lyr
	cate be executed physician and the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Sche	consequence of):	dianyop	attry			3412
68760,	ficate be e physician is the buri	dlcal		d. Dege	meatire	dric d	isease			4411
.O. Box	at the death certific by the attending p tached for use as a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 MNo 9 ☐ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at t 9 ☐ Unknown	2 ☐ Fetal death 3 ☐	Ectopic pregnancy Other (specify)			23d. Date Mont	of delivery h Day Year
<b>a</b>	The law requires that the site has been signed by the bage 2 should be detache	by	Part II. Other significant conditions of		t not resulting in the un	derlying cause give	n in Part I.			oute to the cause of death?
Vital Records,		Completed						24a. Was ar autops perform 1 \sum Yes 2	/ pri led? de	ere autopsy findings available or to completion of cause of ath?
Division of Vit	문 등 등	atlon: To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending investigation	Hospital: 1 ☐ Inpatien 28a. Date of Injury (Month, Day	28b. Time of	28c. Injury Work	r: 4 🗆 Nursing	eath (Check only one Home 5 Reside 28d. Describe ho	nce 6 Other	
Divis	el or Atta s after de il Directo id in by th	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injur building, etc.	ry - At home, farm, stre (Specify)	eet, factory, office		28f. Location (Str City or Town,	eet and Number State)	or Rural Route Number,
	To the Hospitel or Attanding within 24 hours after death. To tha Funeral Director: After completely filled in by the funer	edical (	29a. Certifier (Check only one) 2 Medical Exam	rsician: To the best of iner: On the basis of and manner stat	f my knowledge, death examination and/or inv ed.	occurred at the time estigation, in my op	e, date and pla inion, death oc	ce, and due to the ca curred at the time, da	use(s) and mann te and place, an	ner as stated. d due to the cause(s)
)	To the comp	M	29b. Signature and title certifier	P1	MARIEN	29c. License	6950	29	d. Date signed (	Month, Day, Year)
ì	5		30. Name and address of person who con Naeweka Ago	ompleted cause of de	ath (Item 23a) (Type, F	orint) Ray	nor B	lud Ste A	Pasal	0, 2005 ma MD 21122
*	Sta Registr		31. Date filed (Month, Day, Year) APR 2 5 200	A Noginal	r's Signature	the state of the s				

JAMES E.FOWLER JR. 05-02700 AMEND ITEM #11&19a&B PER INF C846 8/26/05 JH.

State of Maryland / Department of Health and Mental Hygiene

1- For State Unpend Item 23a&27 per me G843 5-12-05 tas

Registrar

Registrar RKD 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) JAMES EDWARD FOWLER, JR. Month **Physician** APRIL 2005 12:41P. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner N/A HARBOR HOSPITAL BALTIMORE | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | May 27, 1963 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Mary and 41 212-88-5671 1**∑**M 2□ F Yrs. Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or Items 23a or 28a-f show the Medical Examinari, and be notified at 1X Yes 2 □ No Baltimore Maryland N/A Direct 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number USA 21225 1130 Inner Circle Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give 14. Race - American Indian, 11. Marital Status Black, White, etc. Never Married 25 Merried filed within 72 hours after 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify Specify White ğ 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Self-Employed permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygien. Important: If them 27 ta marked other the any injury or other trainments. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Marilyn L. Wright James Edward Fowler, Sr. 2 19b. May 624 remARTEOTRINE AVERAL PRATTINORE Mr. St. 21225 19aMARTTYNEMP/Relaipout ERe. (MOTHER) Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Bayview Crematory, Inc. 4/22/2005 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) McCully-Polyniak Funeral Home, P. 237 E. Patapsco Ave., Balto., Md. 21. Signature of Fyneral Service Licensee Ecker Kevin E 21225-1856 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Hypertensive Cardiovascular Disease Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-tran and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 □ Yes 2 □ No Month Day Year 4☐ Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ₱♣∀es 2 □ No 24a. Was an 1X Yes 2 No director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 XYes 2 No this 27. Manner of Death 1 Natural 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: After Hospital or Attending 5 Pending investigation 1 Tes 2 No after death. 2 Accident by the 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗀 Suicide determined 4 \ Homicide filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier OCME APRIL 18, 2005 80. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street Baltimore, Maryland 21201 RWB10 M Spark 32. Projistrar's Signature 31. Date filed (Month, Day, Year) State APR 2 5 2005 a ser

DHMH 17 Rev 1/2001

Registrar

**Funeral** 

Director

or 28a-f ehov

or Items 23a

Physician

/Medical

Examiner

physician and the burial-transit

other treumatic event, the Medical Examiner must be nutified at

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 0 5 1- State Registramend ITEM #12 PER FH 8842 4/25/05/25 of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Year 10:05 1 20 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner OF BAITIMORE BAITIMORE INAI OPPITAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 01/15/1954 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1□M 2NF 213-52-9032 MD Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🕅 No BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2718 SMITH AVENUE 21209 by Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

Yes 22500
If Yes, Give
Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: WHITE 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) CLERK RETAIL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be FRATER ALVIN **ESTELLE** KAMINETZ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ALVIN FRATER / FATHER 3601 CLARKS LANE UNIT 212 BALTIMORE, MD 21215 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State ' 4 ☐ Donation 5 ☐ Other (Specify) HAR SINAI 04/22/2005 OWINGS MILLS, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee Tolet 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) BrAdtarrathmia Due to (or as a consequence of) BrAIN H + POXIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 4□Pregnant at time of death Month Day Year 5 Other (specify) 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performeda 2 No 2 No 1 🗌 Yes 25. Was case referred to medical 26. Place of Death Check onl one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 2 1 🗌 Yes npatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Mann of Death 28b. Time of Certification: 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 16es -000 2005

The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physicien: within 2

Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) APR 2 5 2005

harles



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Griffith

**ORIGINAL** 

		For State Registrar		aryland / D	Department	of Health and I of Death	Mental Hygie	9	13925
Physicia /Medio Examin	al	Decedent's Name (First, Middle, Rose Gabor  4a. Facility Name (If not institution,		)	4b. City, 1	Town, or Location of Death	2. Date of Death	Day Year 22, 200 1	
Funeral Director		5. Social Security Number 075-26-5972  Usual Residence of Decedent		ge (In yrs. last birt 98	thday) If Under Months Months	1 Year If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Ye Jan 2,	9. Birt	hplace (State or Foreign untry) NY
ie Maryland 8a-f show diffed at	Director	10a. State 10b. County MD Baltimo	re	10c. City, Town	n or Location nsville				10d. Inside City Limits 1 ☐ Yes 2 No
h with th		701 Maiden Choic	e Lane		10f. Zip	Code 1228	10g.	Citizen of What Co USA	ountry?
72 hours after death with the Marylan 72 hours after death with the Marylan 72 hours or 1884 of \$80	by Funeral	11. Marital Status  1 Never Married 2 Marrie  3 Widowed 4 Divorced	12. Was Decedent Armed Forces' d 1 Tyes 2 1 If Yes, Give Year or Dates:	?	13. Was Deceding Yes, spec	ent of Hispanic Origin? (S fy Cuban, Mexican, Puert XXNo Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, Whit Specify: Wh	e, etc.
be filed within 72 hours after death with the Maryland Hygione. 4 other than "natural" or items 23a or 28a-f show event, the Modical Examiner must be notified at	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education grade completed)  College (1-4or	F.\\	Decedent's Usua (Give kind of worn life. DO NOT us Homemake	k done during most of wor e retired)	king	Kind of Business/	Industry
5	To Be C	17. Father's Name <i>(First, Middl</i> e, Lauis Astor				Sarah W			
		19a. Informant's Name/Relationshi Stanley Gabor	p (Type, Print)			(Street and Number or Ru ver Hill Roa			<i>Zip Code)</i> 21218
00		20a. Method of Disposition  1   → Burial 2   → Cremation 3   → 4   → Donation 5   → Other (Specific Action 1)	Removal from State	'	Disposition (Namy, crematory or ot	1		. Location - City or Igeway, N	
permit. Pages Department of Important: If I any injury or once.		21. Signature of Funeral Service L		ire suu.		Address of Facility neral Home,		igeway, N	i
Physician American Am	Examiner	23a. Part 1. Enter the lise se, inc. shick, or heart failur. List Immedia - Cause (Final disease of condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as	d the death. Do nine.	not enter the mode	in Hwy SW, Go of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death
death certificate be ere attending physician of for use as the burian	Physician/Medical E	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	d	e of pregnancy 2  ☐ Fetal death	3 □Ectopic pre			23d. Date of del	ivery Day Year
. 0 0 0	hysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Pregnant a 9☐ Unknown	at time of death	5 ☐ Other (spe	ecity)			,
uires that n signed b	þ	Part II. Other significant condition	s contributing to death	but not resulting in	the underlying ca	use given in Part I.	23e. Did tobaco		the cause of death?  obably 4 Subhnown
vical necolors, r siclan: The law requires that the certificate has been signed by the rector, page 2 should be detache.	Completed						24a. Was an autopsy performed	? death?	atopsy findings available completion of cause of 2 No
g Phys er this eral di	ition; To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending investige	Hospital: 1 Inpati 28a. Date of Inj (Month, Di	ury 28b. T	tpatient 3 DO.		ome 5 Residence 28d. Describe how in		cify)
5 # # # E	Certification;	3 Suicide 6 Could not determine	ot be 28e. Place of In	ijury - At home, fa tc. <i>(Specify)</i>	rm, street, factory	office	28f. Location (Stree City or Town, S		ural Route Number,
To the Hospital within 24 hours of for the Funeral to the Funeral completely filled	Medical	29a. Certifier 1 Certifying (Check only 2 Medical E	Physician: To the best xaminer: On the basis and manner s	of examination and	dor investigation,	t the time, date and place in my opinion, death occu	, and due to the cause rred at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
To th Withir To th comp	Me	29b. Signature and title of certifier		1	290.	License number	29d. \(\)	Date signed (Monti	h, Day, Year)
1		30 Name and address of person w	to completed cause of	death (Item 23a) (	(Type, Print)	D4 1000	0 11	buls	5,2005
Sta Registr		31. Date filed (Month, popy, Year)	2005 32 Regist	Maide trar's Signature	Goods	ice Lane	, Baltim	ore, MI	D 21228

			1- For State of Maryland / Dep Ce	artment of Health and Me	ental Hygier		13837
	Physici	an	Decedent's Name (First, Middle, Last)	2	2. Date of Death Month	Day Yeer	3. Time of Death
	/Medic		JANE E. GEIST			9, 2005	5:30A M
	Examir	ier	4a. Fecility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Deeth	
	Funeral		Misty Ridge 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	Westminster    If Under 1 Year   If Under 24 Hrs.   8	8. Date of Birth	Carro	
	Director		217-16-1435 1 M 2XDF 82 Yrs.	Months Days Hours Min.	(Month, Day, Ye April 5,1	923 Coul	olece (State or Foreign ntry)  MD
2	>		Usual Residence of Decedent				
laryla	a hov	5	10a. State 10b. County 10c. City, Town or L				10d. Inside City Limits 1 ☐ Yes 2X☐ No
the M	28a-f	Directo	MD Queen Anne's Cheste	10f. Zip Code	100	Citizen of What Cou	
with	3a or		1745 Harbor Drive	21619	log.	USA	intry :
death	Tas 2;	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (Spec	ofy Yes or No-	14. Race - Ameri	
:1 215-0036 Within 72 hours after death with the Maryland	tal hygiene. d other than "natural", or Items 23a or 28a-f ahow avant, I'ra Medical Exactinar must ba notitied at	by Fur	Amed Forces?  1 □ Never Married 2 □ Married 1 □ Yes 2 □ No  1 □ Yes 2 □ No  If Yes, Give  Year or Dates:	If Yes, specify Cuban, Mexican, Puerto Ri  1 ☐ Yes 2 🌠 No Specify:	ican, etc.)	Black, White, Specify: Wh	etc. nite
2 Po	Cal		15. Decedent's Education 16a. Dece	edent's Usual Occupation	166	. Kind of Business/In	dustry
215 thin 7	Med n	Completed	(Specify only highest grade completed) (Giv.  Elementary/Secondary (0-12) College (1-4or 5+)	e kind of work done during most of working DO NOT use retired)	9		
21 M	Hygien other th	S	12	Hairdresser		Beauty Sh	ор
	aven aven	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name (	(First, Middle, Maid	den Sumame)	
Nould	d Mer narke	ပ	John E. Baker		l Tasker		0-41
Maryland 21215-003	ilth and Mental Hygie 27 is merked other t r treumatic avant, th			ing Address (Street and Number or Rural).  Harbor Drive, Ches			o Code)
re, N	Hear sthe		20a. Method of Disposition 20b. Place of Disp	osition (Name of Da		Location - City or T	own, State
Pages			1 Durial 2 Acremation 3 Demoval from State	omatory or other place)  Cremation 4/20/	/05	Hampstead	MD
Baltimore,	Department Important: Il any injury o		Carrott	22. Name and Address of Facility		Reisterst	
m a	8 = 8		James & love	Eline Funeral Home		rstown, M	
			23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.				Approximate Interval Between
	ysician	7	Immediate Cause (Final COPD - Ch I	onic obstructive	e		Onset and Death
	Medical aminer		resulting in death)  Due to (or as e consequence of):	onic obstructive	lonory	disease	
		-	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):		0		·
petr	ınsit	Examine	cause. Enter Underlying Cause (Disease or injury				
<b>),</b> өхөсг	n and ial-tra	Еха	that initiated events resulting in death) Last C. Due to (or as a consequence of):				
8/60 ate be	physician and the burial-transit	dical					
∯ ō	ng ph as th	led	(F.F.) F.				
death	the attending p	Physician/Me		□Ectopic pregnancy □ Other (specify)		23d. Date of delive Month	Pery Day Year
J. Interest	signed by the a		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacc	co use contribute to	the cause of death?
VITAL RECORDS, P.O.	been sign should be	ted by	peripheral vascular de chionic lower extremi		1 X Yes	2□No 3□Pro	bably 4 Unknown
\$ & C	a 2 sh	Completed	Chionic lower extremi	tyulcers	24a. Was an autopsy	prior to co	opsy findings available ompletion of cause of
	cate has	S	coronary artery disea	se	performed 1 ☐ Yes 2 🕱		2 No
VIC	is certificate director, pag	Be	25. Was case referred to medical examiner?  Hospital: Hospital:	26. Place of Death			
<u> </u>	this rai dir	To.	1 ☐ Yes 2 ♠ No ☐ Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie  27. Manner of Death 28a. Date of Injury 28b. Time		e 5 Residence	6 Other (Speci	fy)
ار او آر	After tune	atlon:	1 Natural 5 Pending (Month, Day Year) Injury	of 28c. Injury at Work?  M 1 □ Yes 2 □ No	od. Describe now i	illary occariou	
DIVISION I or Attending	r death. actor: A by the tu	ifica	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, s		8f. Location (Stree	t and Number or Rur	al Route Number,
בֿ ב <u>ֿ</u>	S affe	Certific	4 Homicide determined building, etc. (Specify)		City or Town, S.	tate)	
a Hospit	within 24 hours after death.  To the Funeral Director: After this completely filled in by the funeral di	edical (	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, deal of the control of the best of my knowledge, deal of t	th occurred at the time, date and place, are nvestigation, in my opinion, death occurred	nd due to the caus d at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
Tot	To #	ž	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month,	Day, Year)
0	4	L	Magnify/ Nalow	120055127	4	120/05	
10	U		30. Name and address of person who completed cause of death (Item 23a) (Type Mary aret Malaro M. D. (30 Love	Print) Point Rd. Sute 10	7 Steve	ensuite A	10 21666
7	Sta Registr		31. Date filed (Month, Day, Year)  APR 2 5 2005  32. registrar's Signature	4			
DHMI	17 Pay 1/20	001	The second of th				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For Stete Registra Certificate of Death Reg. No. 2. Date of Death Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 6, /Medical 4c. County of Death 4b, City, Facility Name (If not institution, give street and number) Town, or Location of Death Examiner † 8. Date of Birth Month, Day, 9. Birthplace (State or Foreign If Under 24 Hrs. Under 6. Sex last hirthday **Funeral** Min Days Hours 1 □ M 2 🗗 244-644-1450 Usual Residence of Decedent Yrs. Director the Maryland 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location Show ral', or items 23a or 28a-f shov Examiner must be notified at 1 THES 2 No Directo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number with Completed by Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural, or liter any in Intervent in Mental Fact I am In Intervent I any in Intry or other traumatte event, II a Mealine East I am 1 Never Married 2 Married 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-49r/5+) and 18. Mother's Name (First, Middle, Majden Sumame, 17. Father's Name (First, Middle, Last) Be P 19b. Mailing Address (Street and Number or Rur I Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20c. Location -20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Other (Specify) 4 Donation eral Selvice Licens 21. Signature of 22. Name and Address of Facility TUNSTA Approximate Interval Between Onset and Death 23a. Par 1. Er mode of dying, such as cardiac or respiratory arrest, or complications that caused the death. Do not enter the Immediate a e (Final disease or endition resulting in death) **Physician** /Medical ue to (or as a consequence of) Examiner Esquentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): physician a Box 68760 Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy 2 Fetal death Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month 4☐Pregnant at time of death 5 Other (specify) P.O. the 9☐ Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 2 🗆 No 3 Probably 1 Tes Completed 24a Was an has autopsy 2 No this certificate 2 No 1 ☐ Yes or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 2000 1 Inpatient 4 ☐ Nursing Home Certification: To 1 🗌 Yes 6 ☐Other (Specify) 2 ER/Outpatient 3□ DOA 5 ☐ Residence 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of After 1 Natural 5 Pending 1 ☐ Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c. License number

4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? within 24 hours after death.

To the Funerel Director: A completely filled in by the fu id 30: Name and address who completed cause of death (Item, 23a) (Type, Print 31. Date filed (Month, Day, Year) State Registrar DHMH 17 Rev 1/2001 **ORIGINAL** 

			1 - For State of Maryland / Department of Health an Certificate of Death		giene)	05	13839
	Physici		TO ACIVS OF LIFERITE GILDELE	2. Date of Dea		OÖ5ar	3. Time of Death 11:15а м
	/Medic Examir			Death	4c. Count	y of Death	
			7903 Brookford Circle Apt. F Pikesville		Bal	timo	re
	Funeral Director		119-01-3659 15 M 25K 96 Yrs.	Hrs. 8. Date of Birt (Month, Date 10-5-	, Year) -08	9. Birth	place (State or Foreign ntry) Md .
	and		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
	Maryl f sho	ō	MD Baltimore Pikesville				1 ☐ Yes 🎞 No
	r 28e	Director	10e. Street and Number 10f. Zip Code		10g. Citizen of	What Cou	ntry?
	th with	al D	7903 Brookford Circle Apt F 21208		U.	S.A.	
92	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel", or items 23a or 28e-f show any injury or other treumatic event, the Medical Examinar must be notified at once.	y Funeral	11. Marital Status  1 □ Never Married 2 □ Married  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Never Married 2 □ Married  12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, P  1 □ Yes 2 ☑ No Specify:	? (Specify Yes or No- Puerto Rican, etc.)	14. Ra Bla Speci	ick, White,	
Ö	hours turel',	ed by	Year or Dates:			BI	Lack
Maryland 21215-0036	within 72 ene. then "nef	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  12th grade  2yrs+  15a. Decedent's Usual Occupation (Give kind of work done during most of life. DO NOT use retired)  Nurse	f working	16b. Kind of 8	spita	
0	illed Hygi other	Be Co		Name (First, Middle,			
ylan	ould be Menta arked atic ev	To B	James A. Jones Carri	e A. Gre	_		
Mar	d 2 shoth and the and the and the treum treum		19a. Informant's Name/Relationship (Type, Print)  Patricia Condrey-Daughter  7903 Brookford C				
	s 1 and f Health item 27 other tr		20a. Method of Disposition 20b. Place of Disposition (Name of	Date Date	20c. Location		
E	Pages nent of I ant: If it		XXBurial 2 Cremation 3 Removal from State  4 Donation 5 Other (Specify)  MD National Park 04	/25/05	Laure	el, N	Md.
Baltimore,	permit. Departn Importe any inju		21. Signature of Funeral Service Licensee  22. Name and Address of Facility  March F.H. West	Ba	ltimore Wabash		21215
	THE		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as car shock, or heart failure. List only one cause on each line.				Approximate Interval Between
E	Physician .		Immediate Cause (Final disease or condition resulting in death)  a. Myock Sigli infection	retion			Onset and Death
	/Medical Examiner		Due to (or as a Lonsequence of):	Q.50	2 - 6 -		
		ner	Sequentially list conditions, if any, Isaam to find client cause. Enter Underlying Cause (Disease or injury	000	5 5 C.		
	ecuted and -transi	Examiner	that initiated events c.				
8760,	ate be executed obysician and the burial-transit		Due to (or as a consequence of):				
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O. Box	at the death certific by the attending p tached for use as	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 5 Other (specify)			ate of deliv	Pery Day Year
o,	requires that been signed b hould be deta	by Pr	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did to	bacco use cor	ntribute to	the cause of death?
ğ	w require been sig should b			_ 101	es 2000	3 ☐ Pro	bably 4 □Unknown
Record	The law ate has b page 2 s	Completed		24a. Was autop perio 1  Yes		Were autoprior to codeath?	opsy findings available ompletion of cause of
Vita	slcian: Th certificate rector, pag	Be (	25. Was case referred to medical examiner? 26. Place of	Death (Check only o	ne)		
	Physician: r this certific ral director,	P	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursin	ing Home 5 Hesio			fy)
Division of	ding F h. After funer	tlon	27. Manner of eath  1 Matural 5 Dending (Month, Day Year)  2 Accident investigation  28a. Date of Injury 28b. Time of Injury Work?  1 Pes 2 No	28d. Describe h	low injury occu	rred	
181	or Attending ter death. irector: After n by the fune	fica	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office	28f. Location (5	Street and Num	ber or Rur	al Route Number,
á	i Qift o	Certification;	4 Homicide determined building, etc. (Specify)	City or Tov	vn, State)		
	To the Hospitel within 24 hours a To the Funerel I completely filled	edical (	29a. Certifier (Check only one)  Certifying Physicien: To the best of my knowledge, death occurred at the time, date and p one)  Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death of and manner stated.	place, and due to the occurred at the time,	cause(s) and m date and place	anner as s	stated. to the cause(s)
	To the within 2 To the complet	ž	29b. Signature and title of certifier 29c. License number		29d. Date sign	ed (Month,	, Day, Year)
	1		1/4 likener 10026;	475	4/2	rde	25
	5		30 Nameland artiress of person who completed cause of death (Item 23a) (Type, Print)	200	, (	(	
	Sta	te	31. Date filed (Month, Day, Year)  32. Registrar's Signature	100		<u> </u>	
	Registr		APR 2 5 2005 Blesser J. April				

_			1- For State of Maryland / Department of Health and Mental Hygiene Certificate of Death  Reg. No. 2005	201.
	Physic /Med	ical	1. Decedent's Name (First, Middle, Last)  JEANNETTE SILLELAND  2. Date of Death  Month Day Year  APRIL 20 2005 12	me of Death
	Exami Funeral	de l	HOWARD (NNT) SEVERAL HOPPIAL COLVINSIA HOWARD	toto or Foreign
	Director Modes		391-26-2269 1 M 2XIF 73 Yrs. Months Days Hours Min. (Month, Day, Year) Country Usual Residence of Decedent  10a. State 10b. County 10c. City Tevre of Learling	ın
	rith the Mary or 28a-f sh	Director	MD Anne Arundel Jessup  10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?	de City Limits  Yes 2∑No
9003	72 hours after death with the Maryland neturel', or Items 23a or 28e-f show alcal Examitrer cust be malified at	by Funerai	7484 Montevideo Court  20794  U.S.A.  11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.)  14. Race - American India Black, White, etc.  15. Was Decedent Ever in U.S. Armed Forces?  16. Yes, Specify: 12. Was Decedent Ever in U.S. Armed Forces?  16. Yes, Specify: 17. Speci	ın,
d 21215-0036	filed within 72 Hygiene. ther than "net nt, tre Music	Completed	17 Esthada Nama (Cine Adidd) ( a)	Flight
Maryland	should be fand Mental is marked of	To Be	18. Mother's Name (Hirst, Middle, Maiden Sumame)	
Baltimore, M	permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "ne any injury or other traumatic event, If a Mental Once.		Claude H. Gilleland /spouse 7484 Montevideo Court, Jessup, Maryland 20792  20a. Method of Disposition  1 Burial 2 Stremation 3 Removal from State  20b. Place of Disposition (Name of cemetery, crematory or other place)  20c. Location - City or Town, State	te
Balti	permit. Departm Importa		21. Signature of Funeral Service Licensee  22. Name and Address of Facility Donaldson Funeral Home & Crematory, P.A.  1411 Annapolis Road, Odonton, Marylanda	
Š.	Physician /Medical		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure/ List only one cause on each line.  Approximately a control of the control of th	
	Examiner	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	
8760,	icate be executed physicism and the burial-transit	dical Examin	that initiated events c	
O. Box 6	the death certifi by the attending pached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 5 Other (specify) Month Day	Year
Hecords, P	requir	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause 1 Yes 2 No 3 Probably 4	
_	2 S a	e Compieted	24a. Was an autopsy finding performed?  25. Was case referred to medical	ngs available of cause of
> i	Physician: this certific rat director,	10 B	examiner?  1   Yes 2   No   Hospital: 2   ER/Outpatient 3   DOA   Other: 4   Nursing Home 5   Residence 6   Other (Specify)	
_	9 9	Certification:	28a. Date of Injury    Natural   5   Pending   28b. Time of Injury   28b. Time of Injury   28c. Injury at Work?   1   Accident   Investigation   3   Suicide   6   Could not be   28c. Date of Injury   28b. Time of Injury   28c. Injury at Work?   1   Yes 2   No	
2			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28e. Place of Injury - At home, farm, street, factory, office City or Town, State)  28f. Location (Street and Number or Rural Route No. City or Town, State)  28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route No. City or Town, State)	
	thin 24 or the Fi	Medical	one) and manner stated.  29h Signature and title of coeffice.	
1	1 6		ASTENDING DOOS 6948 APRIL 21 200	05
9			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  TAMES TANSINDA 522 DOLPTIN STRUCT BALTIMORE NO 21917	
	State Registra	٠	31. Date filed (Month, Day, Year)  APR 25 2005  APR 25 2005  APR 25 2005  APR 25 2005  APR 25 2005	

#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Deeth 1. Decedent's Neme (First, Middle, Last) Month Dev Year Physician April 11:55 An orothea 20 2003 /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4e Fecility Neme (If not institution, give street end number) Examiner Bas Hmore romwell BALTIMORE NUrsing If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yeer) Birthplece (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. lest birthday) **Funeral** Days Months 1 □ M 2K F 215-05-1307 Yrs Director 9/4/1917 MARYLAND Usual Residence of Decedent filed within 72 hours efter deeth with the Meryland 10c. City, Town or Location 10d. Inside City Limits Herna 23a or 28e-f sho BALTIMORE MD PARKVILLE Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8729 LACKAWANNA AVENUE 21234 USA Funeral 14. Race - American Indian, Black, White, etc. 11. Maritel Status 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☐ Mo If Yes, Give Year or Dates: 1 ☐ Never Merried 2 X Married 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0020 Specify: WHITE ģ 3 Widowed 4 Divorced Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) TELEPHONE Elementary/Secondary (0-12) College (1-4or 5+) KEY PUNCH OPERATOR 1 YEAR COMMUNICATIONS 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be . Peges 1 end 2 should be fil ment of Health end Mentel H lant: If Item 27 Is marked ott NELSON J. PEARSALL, SR. CATHARINE MUELLER 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Relationship (Type, Print) GEORGE H. GERHOLD, JR./HUSBAND 8729 LACKAWANNA AVENUE BALTIMORE, MD 21234 Depertment of Heal Important: If Item 2 eny Injury or other 20b. Place of Disposition (Name of cemetery, cremetory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Buriel 2 ☐ Cremation 3 ☐ Removal from State MOST HOLY REDEEMER CEM. 4/25/05 BALTIMORE, MD 4 ☐ Donetion 5 ☐ Other (Specify) 22 Name and Address of Fecility THE JOHNSON FUNERAL HOME, P.A. 21. Signature of Funeral Service Licensee TOWSON, MD 8521 LOCH RAVEN BLVD. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** whathmen Immediate Ceuse (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of Physician/Medical Examiner The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of) Box 68760. Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of geath? Part II. Other significant conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. P.0. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown ģ 24b. Were eutopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed? 2 No 1 ☐ Yes 2 ☐ No 1 Yes 25. Was cese referred to medical

Division of Vital Records. efter deeth

To the Funeral Director: youndletely filled in by the within 24 hours e

Be Completed Certification: To

edical

31. Dete filed (Month, Day, Year) State Registrar

1 Yes 2 No

5 Pending

investigation

6 Could not be determined

27. Mennet of Deeth

1 Neturel

2 Accident

3 Suicide

29a. Certifier (Check only

4 Homicide

29b. Signature end title of certifie Own, MD

Laven

28c. Injury at Work?

1 Yes

2 No

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, end due to the ceuse(s) and manner es steted.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end manner steted. 29d. Date signed (Month, Dey, Year)

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

1 ☐ Yes 2 X No

30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print)

5601 Loch

Hospital: 1 | Inpatient 2 | ER/Outpetient 3 | DOA

28b. Time of

28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

Registrer's Signeture

				1- For State of Maryland / Department of Health a Certificate of Death		Hygien	71115	)	1384	12
	b	Physici	an	1. Decedent's Name (First, Middle, Last)	Mon	of Death	ay Yea	ar	3. Time of De	
		/Medic	al	Marleen E. George  4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location	of Death		c. County of D		11:42	TH M
		Examir	er	Grod Samaritan Hospital  Baltimore	or Death		N/A	oauı		
		Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 1 Year Hours	24 Hrs. 8. Date	of Birth	· · · · · · · · · · · · · · · · · · ·	Birthpla Counti	ace (State or F	oreign
		Director		213-36-4644 1 M 2 XF 65 Yrs. Months Days Hours Usual Residence of Decedent		e 1, 1			yland	
		ow iii		10a. State 10b. County 10c. City, Town or Location				10	d. Inside City I	Limits
		ith the Marylen or 28a-f show te notified at	ctor	Maryland Baltimore Baltimore					1 Yes 2	No
		or 28	Director	10e. Street and Number 10f. Zip Code	- ·	10g. C	itizen of What	Count	ry?	
		death with the Marylend ms 23a or 28a-f show Lindst be milling at	erai	545 South 47th Street         21224           11. Marital Status         12. Was Decedent Ever in U.S.         13. Was Decedent of Hispanic Or	rigin? (Specify Ves	Uni	ted Sta	ates	n Indian	
	ဟ	or Item	Funeral	Armed Forces? If Yes, specify Cuban, Mexica  1 □ Never Married 2 □ Married 1 □ Yes 2 ☑ No		ic.)	Black, W	Vhite, e	tc.	
	03	ural', c	d by	3 Wildowed 4 □ Divorced If Yes, Give Year or Dates:	**		Specify:	Wh:	ite	
	Maryland 21215-0036	n 72 h	Completed	15. Decedent's Education (Specify only highest grade completed)  [Give kind of work done during most life. DO NOT use retired)	st of working	16b.	Kind of Busine	ess/Ind	ustry	
	212	d withi	omo	Elementary/Secondary (0-12) College (1-4or 5+)  12 years Secretary		100	Church			
	pu	al Hyg	Be	17. Father's Name (First, Middle, Last)  18. Moth	ner's Name (First, I	Aiddle, Maide	n Sumame)			
	yla	d Meni narke	ပို		ine J. B		T	. 797-	0- 4- )	
	Ma	id 2 sh ith and 27 is r	ļ	19a. Informant's Name/Relationship (Type, Print)  Janet L. Pierorazio  4112 Westmeath Roa		-	Maryla			
	Fe,	of Heal		20a. Method of Disposition 20b. Place of Disposition (Name of	Date	-	Location - City			
	Ë	Page ment c ant: If ury or		1 Labural 2 Cremation 3 Linemoval from State	4/23/200	5 Bal	timore	, Ma	aryland	£
	Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryle Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "netural; or Items 23s or 28s-1 show any injury or other treumatic event, it a Madical Exercited to ask to malified at ODGs.		21. Signifure Funeral Fractice Licensee  22. Name and Address of Facility Load Ruck Fune		of Du	ındalk.	Tn		
		402 # d		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as	uc Dund	all, M	larvlan		1000 Approximate	
-		Physician		shock, or heart failure. List only one cause on each line.					Interval Betwe Onset and De	en ath
	1	/Medical		disease or condition resulting in death)  a. Due to (or as a consequence of):	Right	umg	Wilse?	u	mou.	
11	ы	Examiner	_	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):						
5		rted	Examiner	cause. Enter Underlying						
2	o,	execu en and rial-tra	Exal	that initiated events resulting in death) Last C. Due to (or as a consequence of):	)					
()	8760	tate be executed oblysicien and the burial-transit	licai	d						
7	9	as as	/Med	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of	f delive	0/	
لأا	Box.	etter for u	Physician/Medical	1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death 5 Other (specify)			Month		Day Ye	ar
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I	of V	hysic his ce	ToE		lursing Home 5 [			Specify	·)	
		Jing P. After 1 funera	tion:	27. Manner of Death  ND Natural 5 □ Pending (Month, Day Year)  ND Natural 5 □ Pending (Month, Day Year)  ND Natural 5 □ Pending (Month, Day Year)  ND Natural 5 □ Pending (Month, Day Year)		scribe how in	ijury occurred			
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	Ö	rs efte ef Dire ed in l		4 ☐ Homicide building, etc. (Specify)	City	or Town, Sta	176)			
		To the Hospitel or Attending Physician: The I within 24 hours effer death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	edicai	29a. Certifier  (Check only one)  2□ Medical Examiner: On the basis of examination and/or investigation, in my opinion, de and manner stated. ♣	and place, and due eath occurred at th	to the cause time, date a	(s) and manne and place, and	er as st I due to	ated. the cause(s)	
		o the	Mec	one) and manner stated.  29b. Signature and title of certifier 29c. License number		29d. [	Date signed (A	Month,	Day, Year)	
				NSalim Baghli MD \$		0	4.20	) - 4	2005	
	1.	9		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  (200 d Semacity House 1 5601 with raver Rint)	exact R	. Itica	οΩ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	N -	7117	. Q.
	Q	Sta		31. Date filed (Month Pay Year)  32. Registrar's Signature	MA (11.9 (7		J. J - 100	1)	0100	
		Registi		31. Date filed (Month, Pay, Year) APR 2 5 2005  32. Registrar's Signature						

December   March   M			For State	State of Ma	ryland / Depa	artment of He rtificate of D	ealth and M	lental Hyg	giene	gible.	
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South Beautiful Number   Color   Col			4a. Facility Name (If not institution, give				ocation of Death	V4.2L			1
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The part of the pa			11. Marital Status 1 Never Married 2 Married	12. Was Decedent E	ver in U.S. 13.	Was Decedent of His If Yes, specify Cuban		ecify Yes or No- Rican, etc.)		Race - Amer Black, White	e, etc.
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Physician Medical Examiner  Ph	. Pages 1. Iment of He tant: If iten		1 ■ Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specification)	y)	LAPEYROL	matory or other place, 18E	05 - 05	Date 2005	20c. Locati	on - City or <sup>*</sup> DAD	rown, State
Shock, or hear failure. List only one cause on each ine.    Mindical Examiner	permit Depar Impor any in		2 angle C.	4	vÃ 51	2. Name and Address UGHN C · GRE 51 BALTO · NE	Of Facility  ENE FUNI  TO PIKE	ERAL SER BALTO .	EVICE MD 21	229	
Due to (or as a consequence of):    Septiment   Street	/Medical		shock, or heart failure. List only Immediate Cause (Final disease or condition	one cause on each line	9.				rest,		Approximate Interval Between Onset and Death
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Second   S	quires that en signed b uld be deta	ρ			not resulting in the u	underlying cause giver	n in Part I.				the cause of death?
27. Manner of Death 1 Natural 2   Accident 3   Suicide 4   Homicide 2   Accident 3   Suicide 4   Homicide 2   Accident 3   Suicide 4   Homicide 2   Accident 3   Suicide 4   Homicide 2   Accident 3   Suicide 4   Homicide 2   Accident 3   Suicide 4   Homicide 2   Accident 3   Suicide 4   Homicide 2   Accident 3   Suicide 4   Homicide 2   Accident 3   Suicide 4   Homicide 2   Accident 3   Suicide 4   Homicide 2   Accident 3   Suicide 4   Homicide 2   Accident 3   Suicide 4   Homicide 2   Accident 3   Suicide 4   Homicide 2   Accident 3   Suicide 4   Homicide 2   Accident 3   Suicide 4   Homicide 4   Homicide 2   Accident 3   Suicide 4   Homicide 4   Homicide 2   Accident 5   Pending investigation 6   Could not be determined 2   Accident 6   Could not be determined 2   Accident 6   Could not be determined 2   Be. Place of Injury - At home, farm, street, factory, office 2   Accident 6   Could not be determined 2   Accident 6   Could not be determined 2   Accident 6   Could not be determined 2   Accident 6   Could not be determined 2   Accident 6   Could not be determined 2   Accident 6   Could not be determined 2   Accident 6   Could not be determined 2   Accident 7   All mure of Death 1   Yes 2   No 2   Nortsing Home 8   Residence 6   Accident 1   Yes 2   No 2   Residence 6   Accident 1   Yes 2   No 2   Residence 6   Accident 1   Yes 2   No 2   Residence 6   Accident   Yes 2   No 2   Residence 6   Accident   Yes 2   No 2   Residence 6   Accident   Yes 2   No 2   Residence 6   Accident   Yes 2   No 2   Residence 6   Accident   Yes 2   No 2   Residence 6   Accident   Yes 2   No 2   Residence 6   Accident   Yes 2   No 2   Residence 6   Accident   Yes 2   No 2   Residence 6   Accident   Yes 2   No 2   Residence 6   Accident   Yes 2   No 2   Residence 6   Accident   Yes 2   No 2   Residence 6   Accident   Yes 2   No 2   Residence 6   Accident   Yes 2   No 2   Residence 6   Accident   Yes 2   No 2   Residence 6   Accident   Yes 2   No 2   Residence 6   Accident   Yes 2   No 2   Residence 6   Accident   Yes 2   No 2   Res	The far ate has page 2	Complet						autop	med?	prior to death?	completion of cause of
Suicide   1   Natural   2   Accident   3   Suicide   4   Homicide   5   Pending investigation   6   Could not be determined   28e. Place of Injury - At home, farm, street, factory, office   28f. Location (Street and Number or Rural Route Number of Rural Route Nu	/sician s cartifi director	8	examiner?	Hospital:	t 2∏ER/Outpatie	Other	-			Other (Snec	eity) Hospice
d M Archany Heley, und Dasass April 22,2003	anding Phy ath. or; After thi		27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day	28b. Time o	of 28c. Injury Work?	at				
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30. Name and address or person with completed cause or geath (item 23a) (Type, Print)	F 3 F 8		I Archi	ny Nile	2 , mo	025	205		APr	1623	
30. Name and address of person who completed cause of Death (Item 23a) (Type, Print)  W. A. Riley GBMC 6701 N1. Chimles St., Bolts Md 2/205  State 31. Date filed (Month, Day, Year) 32. Apgistrar's Signature	Stat	e	W.A. Riley	GBINC	6701 M	1. Charles	St. Bal	eto md	2/	20%	

DHMH 17 Rev 1/2001

Registrar

APR 2 5 2005

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No.) 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Physician HENRY HOWE JR. 3.46 A M 25 23 06 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner UNION MEMORIAL HOSPITAL BALTIMORE N/A If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth 0 2 7 4 4 4 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 212 42 1816 XXM 2DF 61 MARYLAND Director Usual Residence of Decedent the Maryland 10a. State 10c. City. Town or Location 10b. County 10d. Inside City Limits "natural", or Items 23a or 28e-f shov cleal Examinar must be notified at MD n/a BALTIMORE 1XXes 2 □ No Be Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 1018 NORTH IRIS AVE 21205 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XXXo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Saltimore. Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify:WHITE Specify: 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) WAREHOUSE FOREMAN 10 permit. Pages 1 and 2 should be filed to Department of Health and Menial Hygie Important: If Item 27 is marked other 1 any injury or other traumatic event, III sonce. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) HENRY D. HOWE SR. HELEN SLATER ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DOLORES ANN HOWE / WIFE 1018 NORTH IRIS AVE BALTIMORE, MD 21205 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ₩ urial 2 Cremation 3 Removal from State SACRED HEART JESU\$ 4/26/05 BALTIMORE, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility CVACH ROSEDALE FUNERAL HOME 21. Signature of Fuperal Service Liminse 1211 CHESACO AVENUE BALTIMORE. MD 21237 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician SEPSIS 3 days disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** LIVER FAILUR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, sician Physician/Medicai as the IF FEMALE: esn 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy 1 Live birth 2 Fetal death ö in the past 12 months? Month Day Year 5 Other (specify) 4☐Pregnant at time of death P.O. 1 ☐ Yes 2 ☐ No detached 9☐ Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by of Vital Records. 99 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed 20 No 1 ☐ Yes 2 ☐ No 1 Yes or Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 ✓ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification; To 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After Division 5 Pending investigation 1 Natural Injury death. 1 ☐ Yes 2 ☐ No after death Director: / d in by the f 2 Accident 3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Hospitel 24 hours a 29a. Certifier ™ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the within 2 To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 2438946 -E13 04-23-05 M.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHAHZAD A. USMANI UNIVERSITY PKWY, BALTIMORE MD 21218 201 EAST 31. Date filed (North, Day, Year) 32. Registrar's Signature State Registrar

			For State	State of Ma	-	epartme Certifica			nd Mental I			-
4	Physicia /Medic Examin	al	1. Decedent's Name (First, Middle, Las WTLLTA  4a. Facility Name (If not institution, give	H	)LLI	\$		Location of	2. Date of Month	ITL :	ay Year 2 00 c. County of Deer	3. Time of Dealth, 5
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	e Maryland Ba-f show diffed at	ctor	Usual Residence of Decedent  10a. State 10b. County  DC		10c City, Town	gton						10d. Inside City Limits
	ath with the 23 and 2	Funeral Director	531 Shepherd St.			2	Zip Code 20011		0.10 7	Uni	itizen of What Co	es
036	within 72 hours after deeth with the Maryland ene. Than "natural", or items 23a or 28a-f show the Musical Exprit or mast the codified at	by	11. Marital Status  1 Never Married 2 Married  *****Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2∑ No If Yes, Give Year or Dates:			cedent of Hi becify Cuba 2 No	ispanic Origi n, Mexican, Specify:	in? (Specify Yes o Puerto Rican, etc.	) No-	14. Race - Ame Black, Whit Specify: B1	e, etc.
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	s 1 and 2 sh of Health and item 27 is n other traun		19a. Informant's Name/Relationship ( Fred Williams/ S		117		dysto		rr. Bowie	e MD		
Baltimore,	permit. Pages 1 Department of H importent: if ite any injury or ott once.		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Specif	y)	Lincol	y, crematory on Cemet	ery	4.	-26-2005	Sui	tland M	
Balt	Depart Depart import any inj once.	(	21. Signature of Funeral Service Licer	Dave	à	2617	Penn	Ave	ope Funei SE Washii	ngton		0
۱ (	Physician		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition	plications that caused one cause on each line a.	the death. Do n	not enter the m	ode of dyin	g, such as c	ardiac or respirato	ry arrest,		Approximate Interval Between Onset and Death
Ц	/Medical Examiner		resulting in death)  Sequentially list conditions,	. STA	consequence	4 51	ACR	AL	UL	CE	R	
,09	eath certificate be executed attending physician and for use as the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	consequence							
687	0 % 0	ledical		d								
.O. Box	The law requires that the death certifical tee has been signed by the attending phy agge 2 should be detached for use as the	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at 1 9 ☐ Unknown	2 Fetal death	3 □Ectopic 5 □ Other					23d. Date of de Month	livery Day Year
Records, P.	w requires that the d been signed by the should be detached	ted by Pł	Part II. Other significant conditions of	-	t not resulting in	the underlyin	g cause give	en in Part I.		Did tobacco		o the cause of death?
		e Comple	25. Was case referred to medical					OC Bloom	1 Y	Was an autopsy performed?	prior to death?	utopsy findings available completion of cause of
Vital	ysicia is certi directo	To Be	examiner?	Hospital: 1 ☐ Inpatier	nt 2 ER/Ou	tpatient 3	DOA Oth	er	of Death (Check o		6 ☐Other (Spe	icify)
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Division of	To the Hospital or Attending Physician: within 24 hours after death of To the Funeral Director: After this certific completely filled in by the funeral director,	Certification:	2 Accident investigatio 3 Suicide 6 Could not b 4 Homicide determined	98 Place of Inju	ry - At home, fa . (Specify)	rm, street, fact		Yes 2 □ N	28f. Locati	on (Street a Town, Sta		ural Route Number,
	e Hospitt 24 hours e Funera letely fille	Medical (	29a. Certifier 1 Certifying Pl (Check only one) 2 Medical Example	nysician: To the best of miner: On the basis of and manner sta	examination an	death occurr dor investigat	ed at the tin	ne, date and pinion, death	place, and due to n occurred at the ti	the cause me, date a	s) and manner a nd place, and du	s stated. If to the cause(s)
	To th To th comp	Me	29b. Signature and title of certifier		0.60		29c. Licens	e number	38671	29d. C	ate signed (Mon	th, Day, Year)
	10		30. Name and address of person who	completed cause of the	eath (Item 23a)	(Type, Print)	-0	DE	2MDAIS		Rov	KIND AF MI
	Sta		31. Date filed (Month, Day, Year)	32 Registra	r's Signature	boerle		1	<u>ारत ते त्र</u> ी	- VI	- IV	The state of the s

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 0217 AM ADMI 2005 Michael Scott Haslock /Medical City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner BALLIMORE Ohns Hopkins None 17 8. Date of Birth (Month, Day, Year)
Apr 11, 2005 Maryland Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 XM 2 ☐ F Yrs. None Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County il Hygiene. • other than "naturel", or Items 23a or 28a-1 show ivent, the Medical Exertational Le notified at 1 ☐ Yes 2€ No Directo Ellicott City MD Howard 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 4412 Whispering Willow Drive 21043 United States Funerai death. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ★ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Introprient: If Item 27 is marked other than "naturel", or Iter any injury or other traumatic avent, the Medical Exemptra once. 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify. þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 0 None None 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Scott Thomas Haslock Tara Susan Javadpour ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Scott Haslock/Father 4412 Whispering Willow Drive Ellicott City, MD 21043 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Gates of Heaven Cem. 4-23-2005 1 4 ☐ Donation 5 ☐ Other (Specify) Wheaton, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. M01044 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervat Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pulmonan **Physician** hours /Medical 12 hours Examiner Renal Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The faw requires that the death certificate be executed Due to (or as a consequence of): attending physician a for use as the burial-Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) 9 Unknown s been signed to should be detail Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 00 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has birector, page 2 s autopsy 1 Yes 25. Was case referred to medical examiner? director. Be 26. Place of Death (Check only one) Hospital: 1 XInpatient Other: 2 No 2 1 Yes 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: To the Hospitel or Attending 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident after death Director: / d in by the f 3 Suicide 6 □ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours aft To the Funerel Di completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier April 12, 2005 D001:0780

Registrar

State

**ORIGINAL** 

400 N. Wolfe St. Bultimore MD 21287

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HUSPITAI

32. Registrar's Signature

ohns Hopkins

APR 2 5 2005

31. Date filed (Month, Day, Year)

Chiew Kim Huynh Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 05-02737 Amend item 1 per me 842 4-25-05 vt. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) April 18 2ď85 **Physician** 11:40 P M Chieu Kim Huynh /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 5000 Block Landing Road Ellicott City Howard If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1**⊠**M 2□ F Yrs. July 6, 1974 Vietnam 30 Director 225 73 1015 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10h Counts in than "natural", or Itema 23a or 28e-f show the Medical Exercine roust be rediffed at 1 Yes 2 No Director MD Howard Ellicott City 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 21043 United States 5004 Ellis Lane filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 250 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced Asian Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 8 CR Daniels Operator 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be . Pages 1 and 2 should be fil tment of Health and Mental H tent: If Item 27 is marked otl jury or other traumatic ever Than Thi Luong Chung Kim Huynh ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 10116 Trinity Lane Manassas, VA 20110 Thanh Luong/Uncle 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If Ite any injury or otl once. 1 Burial 2 Cremation 3 Removal from State Cemetery, crematory or other place)
4 Donation St Other (Specify entombment Meadowridge Mem. Park 4-25-2005 Elkridge, MD 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 21. Signature of Funeral Service Licensee 4112 Old Columbia Pike Ellicott City, MD 21043 non 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) INJURIES **Physician** MULTIPLE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine and I-transit The law requires that the death certificate be executed Due to (or as a consequence of): burial-Division of Vital Records, P.O. Box 68760, physician Physician/Medical as the l attending p for use as IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown signed to 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ∠Yes 2 □ No 24a. Was an page 2 s autopsy performed 2 No certificate Physician: 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) at Scene Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1X Yes 2 No 2 his. After this funeral d 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: DRIVER OF CAR INVOLUTED IN Hospitel or Attending 1 Natural 5 Pending investigation 11:19PM 1 Yes 2 No 4/18/05 death. 2 Accident COLLISION after death Director: 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by determined 4 Homicide Within 24 hours and To the Funeral Directory ROAD 5000 LANDING RD, ELLICOTT CITY, HO 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. icai 29a Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier April 19, 2005 OCME ello. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

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31. Date filed (Month Pay Year,

, MD

32. gistrar's Signature

RUBIO

2005

111 Penn Street

Baltimore, Maryland 21201

		1	For State Registrar	State of M	laryland		ırtment <i>tificate</i>			Mental	Hygie Reg.	201	15	13848
	Physicia /Medic	an	1. Decedent's Name (First, Middle	o, Last)			HAS	H		2. Date Mon APR		12 21	Year	3. Time of Death  06 % 05 A M
	Examin		4a. Facility Name (If not institution	, give street and number	)	0	4b. City, 1	own, or L	ocation of Dea	ith		4c. County	of Death	
			5. Social Security Number	6. Sex 7. A	EDICAL ge (In yrs. las	CENT	If Under	/ <i>)</i> 4 (	TIMORE If Under 24 Hr	s. 8. Date	of Birth	N/	9. Birth	place (State or Foreign
	Funeral Director		229-34-0388	1 <b>X</b> M 2□F	82	Yrs.	Months	Days	Hours Mir	Jul	of Birth oth, Day, Ye y 13,	1922	Cou	ntry) Ginia
	D		Usual Residence of Decedent		T									
	show	_	10a. State 10b. County			Town or Lo timor								10d. Inside City Limits  1X Yes 2 □ No
	Ba-f s	octo	MD N/A		Dai	CHIOI		0-4-			100	. Citizen of W	/bat Cau	
	with the	吉	10e. Street and Number 3213 Eastern Av	zonije			10f. Zip	1224			109		JSA	intry :
	ns 23	era	11. Marital Status	12. Was Deceden	t Ever in U.S.	13. V	Vas Deced	ent of His	panic Origin? (	Specify Yes	or No-	14. Race	- Ameri	can Indian,
36	within 72 hours after death with the Maryland ene. than "tetural", or Items 23a or 28a-f show the Madical Examiner must be notilied at	by Funeral Director	1 Never Married 2 Marr 3 Widowed 4 Divorced	Armed Forces	:? ] No	li li	fYes,spec 1□Yes 2	ify Cuban	Specify:	nto Rican, e	tc.)	Specify:	k, White, Whi	
21215-0036	2 hou	ted	15. Decedent	t's Education		16a. Deced	ient's Usua	l Occupat	tion	n dela m	16	b. Kind of Bu	siness/Ir	ndustry
212	hln 7. 9. Medi	pie	(Specify only highes Elementary/Secondary (0-12)	College (1-40)	r 5+)	life. L	DO NOT us	e retired)	ıring most of w	orking				
	filed wil Hygien other th	Completed	6 years			Mana	ger_		40.14.15.1.11	(5'		eauty		on
Maryland	ould be fil Mental H arked oth atic even	Be	17. Father's Name (First, Middle, William Hash	Last)					18. Mother's Na Mary H			iden Sumami	Θ)	
Ž	2 should and Me is mark aumatic	<u>م</u>	19a. Informant's Name/Relations	hip (Type, Print)					nd Number or I	Rura/ Route	Number, C			p Code)
	1 and 2 Health a tem 27 is		Molene Stenger	Daugh					t, Balt					
altimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importants if item 27 is marked other than "natural", or items 23a or 28a-1 show amy injury or other traumatic event, the Madical Examiner must be notilized at any injury or other traumatic event, the Madical Examiner must be notilized at any injury or other traumatics.		20a. Method of Disposition  1X Burial 2 ☐ Cremation  4 ☐ Donation 5 ☐ Other (S			ce of Dispo netery, crem ns Of				riΰ26 2005	,	s. Location - osedale		
Balti	permit. Pages 1 Department of H Important: If ite any injury or ot once.		21. Signature of Funeral Service	Licensee	elle	22 C	Name an Connel 1110 S	d Address Ly F Olle	uneral rs Poir	Home nt Roa	Of Du	ndalk, ndalk,	P.A MD.	<sup>A</sup> . 21222
			23a. Part 1. Enter the disease of shock, or heart failure. List	complications that caus	ed the death									Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Λ	STOLL									Onset and Death
	/Medical Examiner		resulting in death)		s a conseque	nce of):	P			, ,	-	4 -		11,100
L		er	Sequentially list conditions, if any, leading to immediate	b. Due to (or a	is a conseque	<u>RB10</u> nce of):	L	ESPI	CATOR		41201	26		ITOURS
	uted d ansit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	S. LIV	ER.	FAIL	URE	=						DAYS
ó	sate be executed oblysician and the burial-transit		resulting in death) Last	Due to (or a	is a conseque		-							, .
8760,	ate be	dical		d										
Ó	leath certifica attending pt I for use as t	/Mec	IF FEMALE:	23c. If yes, outcom	ne of pregnanc	ev .						23d. Dat	e of deliv	verv
D. Box	ne death certificate be executed the attending physician and hed for use as the burial-transif	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live birth	2 ☐ Fetal d at time of dea	eath 3	∃Ect <i>o</i> pic pr ∃ Other (sp			-		Mor		Day Year
P.O.	that the de ned by the a detached t		Part II. Other significant condition	ons contributing to death	but not result	ing in the u	nderlying c	ause give	n in Part I.	236	e. Did toba	co use contr	ribute to	the cause of death?
rds	quires tha n signed I uld be det	ed by								-	1 🗌 Yes	2 🗆 No	3 Pro	bably 4 Onknown
of Vital Records,	e law requires has been sign ge 2 should be	Completed						_		248	a. Was an autopsy performe		Vere aut prior to c leath?	opsy findings available ompletion of cause of
alF	The page		25. Was case referred to medica	4					26. Place of D			No 1	☐ Yes	21 No
<u>S</u>	Physiclan: this certificand director,	o Be	examiner?  1 Yes 2 No	Hospital: 1 npa	atient 2 DE	R/Outpatier	nt 3 DC	Othe	~			e 6 □Othe	er (Spec	ify)
n of	ding Phy J. After this funeral d	on: To	27. Manner of Death  1 Natural 5 Pendii	28a. Date of Ir		8b. Time o	f 2	8c. Injury Work	at ?			injury occurr		
isio	ten leath tor: the	Icati	3 Suicide 6 □ Could		Injury - At ham	ne farm sti	M reet factors		′es 2□No	28f. Loc	ation (Stre	et and Numb	er or Ru	ral Route Number,
Division	p # F =	Certification:	4 Homicide determ	building,	etc. (Specify)	10, 121111, 5(1	ieer, racion	, DITICE			or Town,			
	To the Hospital or Att within 24 hours after of To the Funeral Direct completely filled in by	edical C	29a. Certifier (Check only one)	ng Physician: To the be Examiner: On the basis and manner	of examination	ledge, deat on and/or in	h occurred ivestigation	at the tim	e, date and pla pinion, death oc	ce, and due curred at th	to the cause time, date	se(s) and ma and place, a	nner as and due	stated. to the cause(s)
	Fo the vithin Fo the somple	₩.	29b. Signature and title of certific	ər			290	. License	number		290	. Date signed	(Month	, Day, Year)
	di		► WX W	MOMPH				RE	5-000			APRIL	22	2005
	^		30. Name and address of person	Who completed cause of	f death (Item 2	23a) (Type,	Print)							
	17		NAMOINE JACKEON	MD JOHNS	HOPICINS	HOSPI	TAL	600	NORTH Y	MOLFE 5	TREET	BALTIMO	RE 1	MARYLAND 2120
**	Sta Regist	ate rar	31. Date filed (Month, Day, Year, APR 2 5 2	Bi .	strar's Signatu	Logue								
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DHMH 17 Rev 1/2001

ORIGINAL

		-	State of Maryland / Department of Health and N  - State Amend Item#16a, per FH, G842, 4/2/105 CE	lental Hy	giene Reg. No. 20	05 13869
		_	Decedent's Name (First, Middle, Last)	2. Date of De	ath	3. Time of Death
	Physicia /Medic		KATRINA L. JONES	04. 20	. 2005	5:20 AM
	Examin	er	4a. Facility Name (If not institution, give street and number)  MANOR CARE NURSING HOME  4b. City, Town, or Location of Death CATONSVILLE		BALTIN	
			MANOR CARE NURSING HOME CATONSVILLE  5. Social Security Number  6. Sex  7. Age (In yrs. last birthday) If Under 1 Year   If Under 24 Hrs.	8. Date of Bir		
	Funeral Director		220 · 20 · 3181 1 M 2 M F 18 Yrs. Months Days Hours Min.	8. Date of Bir (Month, Da	1921	Birthplace (State or Foreign Country)  PA
	ъ		Usual Residence of Decedent	10 1 0.1		10d. Inside City Limits
	arylar show	<u>~</u>	10a. State 10b. County 10c. City, Town or Location BALTIMORE			1 KEYes 2 □ No
	the M	ecto	MD NA BALTIMUKE.  10e. Street and Number 10f. Zip Code		10g. Citizen of Wi	hat Country?
	3a or	<u>.</u>	104 N. KOSSUTH STREET 21229		USA	
	filed within 72 hours after death with the Maryland Hygiene. sther than "natural", or Items 23a or 28a-f show ant, Ite Medical Examinat must be notified at	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No	14. Race	- American Indian, , White, etc.
98	or Ite	F	1 □ Never Married 2 □ Married 1 □ Yes 2 ■ No If Yes, Give 1 □ Yes 2 ■ No Specify:	,,		BLACK
8	hours tural',	d by	3 KWidowed 4 □ Divorced Year or Dates:  15. Decedent's Education 16a. Decedent's Usual Occupation		16b. Kind of Bus	
7.	In 72 n "na realic	Completed	(Specify only highest grade completed) (Give kind of work done during most of work life. DO NOT use retired) That ruct	tional		,
212	d with giene	mo	Elementary/Secondary (0-12)  IZ TH GRADE  College (1-4or 5+)  YR.  STRUCTURAL ATDE	Aide	BALTIMO	RE CITY
2	be file tal Hy d othe svent,	Be	17. Father's Name (First, Middle, Last)  18. Mother's Name  (MN 0.005)		-	)
<u>y</u>	ould h	ဍ	STANLEY JACKSON MILDRED	WHITE		State Tin Contail
Mar	12 sh h and 7 Is rr traum		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Run  5231 RACCOON CT., CO	Lumbia	-	21045
Ġ,	1 and Healt tem 2		20a Method of Disposition 20b. Place of Disposition (Name of	Date		City or Town, State
9	Pages ent of nt: If if		1 Burial 2 □ Cremation 3 □ Removal from State  1 □ Burial 2 □ Cremation 3 □ Removal from State  1 □ Donation 5 □ Other (Specify)	5.05	BALTO. N	MD
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatih and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility YAUGHN C. GREENE FUN	JERAL SI	ERVICE	0
	40744		23a. Part1. Entertibe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac			Approximate
	Dharistan		shock, or heart failure. List only one cause on each line.			Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)  Due to (or as a consequence of):		ncer	245
	Examiner		Sequentially list conditions b.			/
	P	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			
	ecute and I-trans	Examiner	Cause (Disease of Injury that initiated events resulting in death) Last Due to (or as a consequence of):			
8760,	certificate be executed ding physiclen and use as the burial-transit	alE				
687	ifficate g phy as the	edic				
√ ŏ	death certifica attending ph	an/M	IF FEMALE: 23b. Was decedent pregnant  1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy		23d. Date	of delivery th Day Year
0.B	0 0 2	Physician/Medical	in the past 12 months?  1		141011	ur Day roar
2 g.	hat th ad by detach	Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did	tobacco use contril	bute to the cause of death?
ds,	uires ( signe	d by		1 🗆	Yes 2	3 ☐ Probably 4 ☐ Unknown
Vital Records	law requires that the as been signed by th 2 should be detache	Completed		24a. Was	an 24b. W	Vere autopsy findings available for to completion of cause of
Re	sician: The law certificate has b irector, page 2 s	шо		auto perfe	ormed? de	eath?
Vital	ian: irtifica stor, p	Be C	25. Was case reterred to medical examiner? 26. Place of Deat			
\$ 50 > 10	Physician: r this certificinal	ဥ	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Ho		dence 6 Other	· · · · · · · · · · · · · · · · · · ·
	ing Phys 1. After this tuneral di	ion;	27. Manner of Death  1 Natural 5 Pending (Month, Day Year)  28a. Date of Injury (Month, Day Year)  28b. Time of Injury Work?  1 Yes 2 No	28d. Describe	how injury occurre	od.
大な大 Division	or Attending after death. Director: After In by the fune	ficat	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office	28f. Location (	Street and Numbe	r or Rural Route Number,
<u>~</u> .≥	after after Dire	Certification;	4 ☐ Homicide building, etc. (Specify)	City or To	wn, State)	
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page		29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur	and due to the	cause(s) and man	nner as stated.
	To the H within 24 To the F complete	Medical	one) and manner stated.			(Month, Day, Year)
	To To	-	29b. Signature and title of certifier/	69	y /	22/05
	d		30. Name and address of person who completed cause of death (Item 23st) (Type, Print)	41		2+730
1	7		marcelian A. Milanen sun 5/6 W. Roll	5 km	Bul	Ir had
	Sta		31. Date filed (Month, Day, Year)  32. Registrar's Signature  APR 2 5 2005			
	Registr	rar	AFR 2 5 2005 Bears to Specific	· -	<u> </u>	

DHMH 17 Rev 1/2001

ORIGINAL

			State of Maryland / Depart		•	•
			1 - Stata Contif	icate of Death		4000 13851
			1. Decedent's Name (First, Middle, Last)	Toute of Boats	Rag. 2. Date of Death	No. 3. Time of Death
	Physici	an			Month April 18	Day Year
)	/Medic		Katherine Johnson  4a. Facility Name (If not institution, give street and number)  4b	o. City, Town, or Location of Death	ADLII IC	4c. County of Death
	Examin	er				
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If	Annapolis Under 1 Year   If Under 24 Hrs.	8. Date of Birth	Anne Arundel  9. Birthplace (State or Foreign
	Director		217-14-6623 1 M 2XIF 85 Yrs. M	onths Days Hours Min.	(Month, Day, Ye Jan. 8 1	920 Maryland
	P .		Usual Residence of Decedent			
	show	_	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits 11X Yes 2 □ No
	89-f	Directo	Maryland Anne Arundel   Annapolis		140	
	with to			10f. Zip Code	109.	. Citizen of What Country?
	s 23	Funeral	701 G1enwood St. Apt. 615  11. Marital Status 12. Was Decedent Ever in U.S. 13. Was	21401  Decedent of Hispanic Origin? (Spe	acify Vas or No-	USA 14. Race - American Indian,
_	ter d	-un	Armed Forces?    Armed Forces   If Ye	Decedent of Hispanic Origin? (Spess, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White, etc.
2	hours after death with the Maryland turer, or Items 23e or 28e-f show at Examinations Learneilled at	by	3 ☐ Widowed 4 ☐ Divorced	Yes 21 No Specify:		specify: Black
5-0036	I within 72 hours after death with the Marylan liene. I then "neturel", or Items 23e or 28e-1 show The Medical Examinations! Lean diffied at	Completed	15. Decedent's Education 16a. Decedent's (Specify only highest grade completed) (Give kind	's Usual Occupation d of work done during most of work	168	b. Kind of Business/Industry
Z	within 7 iene. then "r	nple	Elementary/Secondary (0-12) College (1-4or 5+)	NOT use retired)	,,,9	
7	filed withir I Hygiene. other then rent, the M	Cor		Custodian		tate Of Maryland
	be filed ital Hyg od other event,	Be	17. Father's Name (First, Middle, Last)		(First, Middle, Mai	<i>'</i>
<u>Ş</u>	should ind Men s marke umetic	70	Frank Johnson		pi Well	<del></del>
Maryland	12 st h and 7 is n treun			ddress (Street and Number or Rura		
	es 1 and 2 should be fil of Health and Mental H f item 27 is marked ott r other treumetic even		Kenneth Watkins (Son) 1806 A  20a. Method of Disposition  20b. Place of Disposition cemetery, crematic cemetery, crematic			1is, Md. 21401 c. Location · City or Town, State
altimore,	Pages nent of nnt: If it			ory or other place) st Cemetery 4/		
	artme orteni injury					Annapolis, Md. t. Annapolis, Md.
n	permit, Page Department of Importent: If any injury or once.		Jan D. Roea May 83 W	n. Reese & Sor	s Mortu	ary, P.A. 21401
	ST 1911		23a. Part1. Enter 1 e disease, or complications that caused the death. Do not enter the shock, or he rif failure. List only one cause on each line.			
	Physician		Immediate Cause (Final	contid into		Interval Between Onset and Death
	/Medical		disease or condition resulting in death)  a  Due to (or as a consequence of):	Concin Inso	Ma	- luk
	Examiner		Sequentially list conditions h.			
	p .≅	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin Cause (Disease or injury			
	and and trans	Examiner	that initiated events c.			
60,	le be executed ysician and e burial-transit	cal E)	Due to (or as a consequence of):			
189	cate physical physica		d			
	eath certificate attending phys I for use as Ihe	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delivery
ROX	atter for u	clar	in the past 12 months?	opic pregnancy her (specify)		Month Day Year
o.	The law requires that the death certificate te has been signed by the attending physoage 2 should be detached for use as the	Physician/Medi	1   Yes 2   No 9   Unknown   9   Unknown			
 J	s that	by P	Part II. Other significant conditions contributing to death but not resulting in the under	rlying cause given in Part I.	23e. Did tobac	co use contribute to the cause of death?
ğ	w require been sig should b				1 🗌 Yes	2 SNo 3 Probably 4 Unknown
ecords,	law re	Completed			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
T,	The law cate has page 2	Com			performed 1 ☐ Yes 2 🔀	d? death?
Vital R	icien: Th certificate rector, pag	Be (	25. Was case referred to medical examiner?		(Check only one)	
ot v	hysic this co	은	1 ☐ Yes 2 ☐ Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient			e 6 Other (Specify)
Ē	ing P	on:	27. Manner of Death  1 28a. Date of Injury (Month, Day Year)  28b. Time of Injury	Work?	28d. Describe how	injury occurred
<u>s</u>	death death stor:	icat	3 Suicide 6 Could not be	M 1 Yes 2 No	28f Location (Stree	st and Number or Rural Route Number,
Division	or A after Direction by	Certification:	4 Homicide determined building, etc. (Specify)	ractory, onice	City or Town, S	
_	To the Hospitel or Attending Physicien: within 24 hours after death.  To the Funerel Director: After this certifica completely filled in by the funeral director,		29a. Certifier Zertifying Physician: To the best of my knowledge, death oc	curred at the time, date and place.	and due to the caus	e(s) and manner as stated.
	e Ho:	edical	(Check only one) 2 Medical Exeminer: On the basis of examination and/or invest and manner stated.			
	To th withir To th comp	Me	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month, Day, Year)
			1 /24 / Dunn	132136	)	4/19/1005
	1K		30. Name and address of person who completed cause of death (Item 23a) (Type, Prin	1 10	(0):	n, MD 2/6/9
		112	Gay J. Sprane 2/08 11.12	-	Cheste,	n, MD 2/6/9
•,	Sta		31. Date filed (Month, Day, Year)  APR 2 5 2005			•
	Regist	al	APR 2 5 2005 Deve &			

		1 - For State Registrar	State of M	aryland / Depa	artment of Heartificate of De		Mental Hygier		100=
Physic /Medi Exami	cal	Decedent's Name (First, Middle, Lasi     Albert Frederick     A. Facility Name (If not institution, give Charlestown Care	Knust street and number)		4b. City, Town, or Lo		Apr. 25	Day Year 2005 4c. County of Dea Baltimo	
Funeral Director		5. Social Security Number 6. Se 219-07-1711		e (In yrs. last birthday) 84 Yrs.	If Under 1 Year If	f Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye May 4, 192	ar) 9. Bir	re thplace (State or Foreign cyland
ne Maryland 8a-f show	ector		imore	10c. City, Town or Lo					10d. Inside City Limits
ath with the 123e or 2 west be re	Funeral Director	719 Maiden Choice			10f. Zip Code 21228		10g.	Citizen of What Co	ountry?
72 hours after death with the Maryland "netural", or Items 23e or 28a-f show olical Examiner must be notified at	þ	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 ☑ Yes 2 ☐ If Yes, Give Year or Dates:	No	Was Decedent of Hispa f Yes, specify Cuban, M 1 ☐ Yes 2 X No 5	anic Origin? (Sp Mexican, Puerto Specify:	pecify Yes or No- p Rican, etc.)	14. Race - Ame Black, Whit	
d within piene. r than "	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12) 12		(Give	dent's Usual Occupation kind of work done durii DO NOT use retired) Printendant	ing most of worl	king 16b.	Kind of Business	
be file	To Be C	17. Father's Name (First, Middle, Last)  John Knust			18	. Mother's Nam Gert	ne (First, Middle, Maid rude Harmo	len Sumame) N	•
, a de de de		19a. Informant's Name/Relationship (T)  Dorothy Knust / W		719 Ma	g Address (Street and	ce Lane	, HR 518,	Catonsvi.	lle, Md.
permit. Pages 1 a Department of Hez Importent: If item any injury or othe		20a. Method of Disposition  1    Burial 2 □ Cremation 3 □ F  4 □ Donation 5 □ Other (Specify)	lemoval from State	Woodlawn	Cemetery	4/28		Location - City or odlawn, I	
permit Depar Impor any in		21. Signature of juneral Service Licens	rich	4	. Name and Address of Name and Address of Name and Address of Name and Name and Name and Name and Name and Name	s Avenue			
Physician /Medical		23a. Part! Enter the disease, or complished, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a	ne.	er the mode of dying, so $R \in \mathcal{N}$				Approximate Interval Between Onset and Death
ficate be executed we have the physician and is the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	a consequence of):					
ath certi	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of del Month	ivery Day Year
w requires that the de been signed by the a should be detached f	by	Part II. Other significant conditions col	^	7	iderlying cause given in	n Part I.	23e. Did tobacco		the cause of death?
n: The law r ficate has be or, page 2 sh	e Completed	25. Was case referred to medical					24a. Was an autopsy performed?	prior to death?	topsy findings available completion of cause of 2 No
Attending Physicien: The Isr death. sr death. ector: Alter this certificate haby the funeral director, page	To B	examiner?	ospital: 1  Inpatie 28a. Date of Inju (Month, Day	nt 2 ER/Outpatien  ry / Year) 28b. Time of Injury	Other: 4	Nursing Ho	th (Check only one)  me 5 Residence  28d. Describe how in		cify)
To the Hospital or Attenvillin 24 hours after deatle To the Funeral Director: Completely filled in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	building, etc		•		28f. Location (Street a City or Town, Sta	ite)	4
To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	Medical	one)	sician: To the best of ner: On the basis of and manner sta	of my knowledge, death examination and/or inv ted.	estigation, in my opinio	on, death occur	and due to the cause( red at the time, date a	(s) and manner as nd place, and due	stated. to the cause(s)
	2	29b. Signature and title of certifier	1. Nr	~6 M.O	29c. License nu	1748		eate signed (Month	, Day, Year) 2005
12+1		30. Name and address of person who co	ARRETT	7/1 MA	Print)  IPEN CNO	DICE 1			E, MD 21228
Sta Registi		31. Date filed (Month, Day, Year)	32. Hegistra	ar's Signature	to have				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Year Month **Physician** 12:33AM April 25 2005 Francis Μ. King /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Catonsville

If Under 1 Year | If Under 24 Hrs. 5455 Laverne Avenue Baltimore 8. Date of Birth (Month, Day, Year) Feb. 26,1937 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours 1**™**M 2□ F Maryland 68 Director 214-34-2950 Usual Residence of Decedent 10d, Inside City Limits death with the Maryland 10c. City, Town or Location 10a State 10b. County 7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Eraminar must be notified at 1 ☐ Yes 2 ☑ No Director Catonsville Maryland Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 21228 5455 Laverne Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ⊆ ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If tem 27 is marked other than "natural", or ther any injury or other traumatic event. 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Food Wholesale Forklift Operator 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Helen Cavey Woode Wallace King 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Catonsville, Maryland 21228 5455 Laverne Avenue Janet King (Wife) 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cometery, crematory of other place)
Meadowridge Memorial
Park 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4-27-2005 Elkridge, Maryland 4 □Donation 5 □ Other (Specify) 22. Name and Address of Facility
Witzke Funeral Home of Catonsville, Inc.
Catonsville, MD 2 21. Signature of Funeral Service License 1630 Edmondson Avenue Catonsville, MD 1228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Adenocarcinoma **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine use as the burial-transit that the death certificate be executed and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 signed by the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐ Pregnant at time of death 5 Other (specify) I Yes 2 □ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by SERD 1 Yes 2 No 3 Probably 4 Honknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No venous Insufficiency 24a. Was an thrombosis Vein 2 No 1 ☐ Yes Deep To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, f 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification; To 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide (Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 04.25.2005 D 19558 0 716 Maidenchoige Lane, Suite 205, Baltimore Md 21228 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD Johnson, 2005 State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3 Time of Death Month Year **Physician** 12:43 8 KLELL 64 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Manor Care Wheaton Montgomery Wheaton If Under 24 Hrs. Hours Min. If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year, Birthplace (State or Foreign Country) **Funeral** Months Deys 1 □ M 2 🖾 F 88 092-12-5892 Director July 4, Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "neturel", or items 23e or 28a-f show the Medical Examiner must be notified at Director MD Montgomery Wheaton 1 ☐ Yes 2√ No 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 11901 Georgia Avenue 20902 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Maritel Status Black, White, etc. filed within 72 hours after 1 Yes 2 No
If Yes, Give
Yeer or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: Specify: White \$ 3 X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry unk Elementary/Secondary (0-12) College (1-4or 5+) pemit. Pages 1 and 2 should be filed w. Department of Health end Mentel Hygien Important: if Item 27 is marked other the eny Injury or other treasment. unk unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) unk Be ( unk ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Manor Care Wheaton 11901 Georgia Avenue Wheaton, MD 20b. Place of Disposition (Neme of 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 🖾 Other (Specify) in state 21. Signature of Funeral Serves Licensee 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street 21201 Baltimore, MD 23a. Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Intervel Between Onset end Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or as a consequence of) Examine attending physician end for use es the burlel-transit The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical that initieted events resulting in death) Last Due to (or es e consequence of): Part II. Other significant conditions contributing to death\_but not resulting in the underlying cause given In Pert I. 23b. Did tobacco use contribute to the ceuse of death? signed by 1 Yes 2 No 3 Probably 4 Donknown à 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? peen certificete hes page 1 🗆 Yes 2 1 No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physicien: within 24 hours efter death.

To the Funerel Director: After this certifica completely filled in by the funeral director; to Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ۵ 1 ☐ Yes 2 ☐ No 2 ER/Outpetient 3 DOA 27. Manner of Death Certification: 28d. Describe how injury occurred 5 Pending investigation 1 Tes 2 🗆 No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 I Homicide 1 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated.
2 Medical Examiner: On the besis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29c. License number 29b. Signature and title 29d. Date signed (Month, Day, Yeer) son who completed cause of deeth (Item 23a) (Type, Print) (are Manos 32. Registrar's Signature State Registrar

			State of Maryland / Department of Health and  1- For State Registrar  State of Maryland / Department of Health and Certificate of Death		iene 	13854
			Decedent's Name (First, Middle, Last)	2. Date of Deat	h	3. Time of Death
	Physici		Louise R. Kopicki	Month Apr. 18,	Day Year	8:25 p. M
	/Medic Examin		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Deat		4c. County of Deat	
	LAGIIII	CI.	Golden Age Guest Home Sykesville		Carroll	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs	8. Date of Birth	9. Birt	hplace (State or Foreign
	Director		220-14-2796 1 M 2 XF 80 Yrs. Months Days Hours Min.	(Month, Day, Aug. 23		untry) ennsylvania
	ס		Usual Residence of Decedent			
	how		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	Ba-fa	cto	Maryland Baltimore Dundalk			1 ☐ Yes 2 XNo
	다 다 or 28	Director	10e. Street and Number 10f. Zip Code	10	0g. Citizen of What Co	untry?
	23a	la	3000 Dunleer Road 21222		United St	
	tems	nue	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - Ame Black, White	
36	or i	by Funeral	1 □ Never Married 2 □ Married 1 □ Yes 2 ☒ No If Yes, Give 1 □ Yes 2 ☒ No Specify:		Specify: Wh	ite
21215-0036	be filed within 72 hours after death with the Maryland tal Hyglene. d other than *natural', or items 23e or 28e-1 show event, the M. digal Examinar musite millied at	d b	3 ☐ Widowed 4 ☐ Divorced Year or Dates:  15. Decedent's Education 16a. Decedent's Usual Occupation		16b. Kind of Business/	Industry
7	n 72	Completed	(Specify only highest grade completed) (Give kind of work done during most of wo life. DO NOT use retired)	orking	TOD. KING OF BUSINESS	moustry
2	withi ene. than	щ	Elementary/Secondary (0-12) College (1-4or 5+)		Railroad	
0 0	filled Hygi thar		+2 COOK  17. Father's Name (First, Middle, Last)  18. Mother's Na.	me (First, Middle, A		
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked othar than "natural", or items 23a or 28a-1 show any injury or othar traumatic event, the Midical Examination at Le nuitled at Once.	o Be	John Wojcik Anna	Lupien		
<u> </u>	shoul nd Me mark	ို	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Ri		City or Town, State, 2	Zip Code)
¥a	id 2 s Ith ar 27 is trau			ur da lle M	arvlard 21	222
ē,	Hea Hea tam		20a Method of Disposition 20b. Place of Disposition (Name of		20c. Location - City or	
<u>o</u>	ages ont of t: If i		1 Burial 2XCremation 3 Removal from State Cometery, crematory or other place) Hilltop Service Corp. 4/2	3/2005	Towson, Ma	ryland
Baltimore,	artme ortan injuri		21. Signatur of Funeral Service Licensee	3, 2003	10wson, Ma	ir y rana
Ba	permi Depar Impo any ir		Duda-Ruck Funeral 7922 Wise Avenue	Home of D	undalk, In	C.
		<	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia			Approximate
L			shock, or heart failure. List only one cause on each line.	r		Interval Between Onset and Death
	Physician / /Medical		Immediate Cause (Final disease or condition resulting in death)  a	siaso		> 1 wenter
×	Examiner		Due to (or as a consequence of).			
		e.	Sequentially list conditions, a pure to (or es a consequence of):			
	uted d ansit	듵	Tally, leading to immediate course. Enter fundarying Cause (Disease or injury			
Ć.	execu n and ial-tra	Examiner	that initiated events c.  resulting in death) Last Due to (or as a consequence of):			· · · · · · · · · · · · · · · · · · ·
8760,	icate be executed physician and s the burial-transit	dlcall	d			
.89	tificat ng phy as th	edle				
Вох	death certifii e attending p id for use as	Physiclan/Me	IF FEMALE: 23c. If yes, outcome of pregnancy   23c. If yes, outcome of pregnancy   1 □ Live birth   2 □ Fetal death   3 □ Ectopic pregnancy		23d. Date of del	,
	death e atte d for	icla	in the past 12 months?  1 □ Yes 2 DEVIO 4 □ Pregnant at time of death 5 □ Other (specify)		Month	Day Year
0	lhat the de ed by the detached	hys	9 Unknown			
٣.		by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tob	pacco use contribute to	the cause of death?
ğ	- v -			1 🗌 Ye	es 2□No 3□Pr	obably 4 Honknown
Records,	> 0 0	ompleted		24a. Was a		itopsy findings available completion of cause of
	lhe te h age	E		perform	ned? death?	/
Vital	ician: certifica rector, p	ပ		eath (Check only on		
	Physician: this certific ral director,	0.0	examiner?  1  Yes 2 No	Home 5 ☐ Reside	ence 6 Other (Spe	cify)
o l		h:	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at (Month, Day Year) 28b. Time of 1907.	28d. Describe ho	ow injury occurred	
ō	Attanding F r death. sctor: After by the funer	atlo	1 ☐ Matural 5 ☐ Pending (Month, Day Year) Injury Work? 2 ☐ Accident investigation M 1 ☐ Yes 2 ☐ No			
Division	of or Attand after death Director: A	ertification;	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (St. City or Town	reet and Number or Ru n, State)	ıral Route Number,
	s afte	Cer				
	To the Hospital or At within 24 hours after or To tha Funeral Direct completely filled in by	dical (	29a. Certifier (Check only   Medical Examine) On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place.	e, and due to the ca	ause(s) and manner as	stated.
	he H in 24 ha Fi plete	0	one) and manner stated.			
	To the within 2 To the complete	Σ	29b. Signature and title of periffier 29c. License number	2	9d. Date signed (Monti	n, Day, Year)
	4		Valuely Tulesur) D 20806		4/21/05	
	1621		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  ATHICK TURNES UP SUITE (OZ / 1000 LIB (1874 / 6	0	Λ α	225
_	107			COAD EL	WETTS BURG.	ND C1784
		ate	31. Date filed (Mora, DR Yaar 5 2005 32 Registrar's Signature			
	Regist	rar	Lateria 12 March			

	ack Indelible Ink. Ensure All	
1- For State of Maryland	/ Department of Health and Mo Certificate of Death	ental Hygiene
		Reg. No. 2005
1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year
Medical Stephen Lib	erq	APRIL 20 2005 5:45p M
kaminer 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
204 WICKLOW AVE	FERNDALE	ANNE ARUNDEL
ral 5. Social Security Number 6. Sex 7. Age (In yrs. last	st birthday) If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Year)  9. Birthplace (State or Foreign Country)
212-12-7004 WM 20F 87		SEPT 13, 1917 MD
Usual Residence of Decedent	Total	
	Town or Location	10d. Inside City Limits
MD ANNE ARUNDEL FER	NDALE	1 ☐Yes 2☐No
10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
	21061	USA
204 WICKLOW AVE  11. Marital Status  1 Never Married 2 Married  12. Was Decedent Ever in U.S Armed Forces?		cify Yes or No- 14. Race - American Indian,
	If Yes, specify Cuban, Mexican, Puerto F	
3 Widowed 4 □ Divorced If Yes, Give Year or Dates: WWII	1 ☐ Yes 2 ☐ No Specify: XX	Specify: WHITE
15. Decedent's Education	16a. Decedent's Usual Occupation	16b. Kind of Business/Industry
15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0·12)  12  College (1-4or 5+)	(Give kind of work done during most of workir life. DO NOT use retired)	09
12	CARPENTER	US GOVT
		(First, Middle, Maiden Sumame)
JOHN LIBERA	SUSAN K	ACZMOCZICK
19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural	
JOHN F. LIBERA BROTHER	3021 INDIANA AVE ROSEMO	•
		ate 20c. Location - City or Town, State
1 Burial 2 ☐ Cremation 3 ☐ Removal from State	metery, crematory or other place)	256. Essation Sity of Form, State
	N HAVEN CEMETERY	GLEN BURNIE, MD
21. Signature of Funeral Service Literage	FINK FUNERAL FACILITY	P.A.
K GREGORY FINK MO1148	120 CHAILN HWI BW GE	EN BURNIE, MD 21061
23a. Part1. Enter the disease, in complications that caused the death. shock, in heart fall see. List why one cause on each line.	Do not enter the mode of dying, such as cardiac of	r respiratory arrest, Approximate Interval Between
Immediate Causi (Final		ORG The Onset and Death
disease or condition resulting in death)  a Due to (or as a consequence)		GM ENTINS
Caraza	RU ARTERU TUCH	fliciency comonths
Sequentially list conditions, Due to (or as a consequentially list conditions)		
if any, leading to immediate cause. Enter Underlying Cause, (Disease or injury	lized Atherus	clerosis
if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of the consequence of the consequence of the consequence of the cause is a consequence of the caus		
d		
JF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	rov .	22d Date of delices
23b. Was decedent pregnant in the past 12 months?	death 3 ☐ Ectopic pregnancy	23d. Date of delivery  Month Day Year
1 Tyes 2 No 9 Unknown 9 Unknown	ath 5 Other (specify)	
Part II. Other significant conditions contributing to death but not result	ting in the underlying course gives in Best I	23e. Did tobacco use contribute to the cause of death?
	ang an are underlying cause given in Part i.	
of Chronic Icenal F	aime	1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknow
Chronic Renal F.		24a. Was an autopsy findings available prior to completion of cause of
E O		performed death?
25. Was case referred to medical	26. Place of Death	
m examiner?	Othors	ne 5 ☑ Residence 6 □ Other (Specify)
F	28b. Time of 28c. Injury at 2	ne 5 Aresidence 6 Other (Specify)  28d. Describe how injury occurred
27. Manner of Death  1 ☑ Natural 5 ☐ Pending  2 ☐ Accident investigation	Injury : Work? M 1 ☐ Yes 2 ☐ No	
2 Accident investigation 3 Suicide 6 Could not be		28f. Location (Street and Number or Rural Route Number,
27. Manner of Death  1	me, farm, street, factory, office	City or Town, State)
(Check only 2 Medical Examiner: On the basis of examination	vledge, death occurred at the time, date and place, a on and/or investigation, in my opinion, death occurre	and due to the cause(s) and manner as stated. ed at the time, date and place, and due to the cause(s)
	00-1:	20d Date stand Atlanta Burya
29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
lown Carsy	1 1015 47	4/2//2005
30. Name and address of person who completed cause of death (Item	23a) (Type, Print)	way Gley Burnie, Md
Coluin Carter 11	EDD (rain Hich	way 6/PUBURNIC, Md
ate 31. Date filed (Month, Day, Year) 32. Registrar's Signate	ure	
tate 31. Date filed (Month, Day, Year) 32. Registrar's Signaturar APR 2 5 2005	W. Anach &	

Please Type or Print in Black Indelible Ink. Er	nsure All Copies Are Legible
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Physic	cian	Decedent's Name (First, Middle     To a see 1-		Joseph	1.7 T _	_12_		2. Date of D	Day Day	, Y	ear 3.	. Time of Death
/Med		Joseph	Lamdin	Joseph	w. La			APRIL	ai	۵	005 1	1:30 A
Exam	iner	4a. Facility Name (If not institution					or Location of Deat	1	4c.	County of	Death, N/A	
Funera		5. Social Security Number	AL OF BAL 6. Sex	7. Age (In yrs. las		BALTIN If Under 1 Year	AORE CIT If Under 24 Hrs.			_		(State or Fore
Directo		212-09-9598	1√2 M 2□ F	90		Months Days	Hours Min.	8. Date of B	7, 191	4   ~	Maryl.	and
200		Usual Residence of Decedent  10a. State 10b. County		100 City	Taura and							
sho	ŏ	MD N/A			Town or Lo	nore City						Inside City Lim XX Yes 2 ☐ I
288-	rect	10e. Street and Number				10f. Zip Code			10a Citi	zen of Wh	at Country?	
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sme	nera	11. Marital Status		cedent Ever in U.S. orces?	. 13.	Was Decedent of I	Hispanic Origin? (S an, Mexican, Puert	pecify Yes or N	lo-		American In	ndian,
or it	y Fu	1 Never Married 2 Mar	ried 1 X Yes If Yes, G	2 □ No ive	1	1 ☐ Yes 2 No		o ricali, etc.)		Specify:	White, etc. White	
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ital Hyg id otha evant,	BeC	17. Father's Name (First, Middle,	Last)				18. Mother's Nar	ne (First, Middl	e, Maiden	Sumame)		
nd Mental markad o	To	James Lamdin					-Cather:	ine Dav	is Id	la C.	Davis	5
and ls m		19a. Informant's Name/Relations	hip <i>(Type, Print)</i> <del>Pife)</del> (Wif	fe)	19b. Mailin 301 W	ng Address <i>(Street</i> V. Lafaye	tte Avenu	ral Route Num 1e Bal	ber, City or timor	e, MD	ate, Zip Code	1 <u>e)</u> 7
f Health item 27 other tr		20a. Method of Disposition		20b. Plac	ce of Dispo	osition (Name of matory or other pla		Date	20c. Lo	cation - Cit	ty or Town, S	State
nent of h		1 ☐ Burial 2 【Cremation 1 ☐ Donation 5 ☐ Other (5	3 □Removal from Specify)	Jiale		h Cremato	1 /-	4-2005	Lau	rel,	Mary1	and
Department Important: I any injury c		21. Signature of Funeral Service		)	22	2. Name and Addre	ess of Facility	0.00				
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٥		23a. Part1. Enter the disease, or shock, or heart failure. List	complications that only one cause on	caused the death.	Will 16	tzke Fun 30 Edmon er the mode of dyir	eral Home dson Aver ng, such as cardiac	or respiratory	tonsv arrest,	ille,	App	oroximate rval Between
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	Physici /Medio		Alphonso	R. LE	MIS					54	Day 22	2005	2220 M
	Examir	er	4a. Facility Name (If not institution, giv	ve street and number) MARYUAN			4b. City, Town,				4c. Coun	ty of Death	
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ylar	should be nd Mental marked c	To E	Alphonso Lewis					Alfr	eda Lew	is			
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89	ifficate g phys	edicai		_ d					w	MEDICAL			
X Q	eath cert attending I for use a	M/ue	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 Live birth			Ectopic pregnance	1	PPROVED BY			ate of delive	ry
о П	The law requires that the death certificate be executed te has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at 9☐Unknown			Other (specify)	CRITICATION	APPROVED BY		Me	onth !	Day Year
, י	res that the de signed by ths a be detached f	by Ph	Part II. Other significant conditions of	contributing to death bu	ut not resultin	g in the ur	nderlying cause giv	ren in Part I.		23e. Did toba	cco use con	tribute to the	e cause of death?
ecords,	w requires been sig should by	ed b	Circhosis							1 ☐ Yes	2 □ No	3 🗌 Proba	ably 429Unknown
eco •	as ben 2 sho	Completed								24a. Was an autopsy	24b.		osy findings available inpletion of cause of
		Con								performe		death?	28-No
Vital	nysician: The law ns certificate has I director, pags 2 s	o Be	25. Was case referred to medical examiner?	Hospital: 📭			Oth			neck on a one			
0	ding Phys h. After this funeral di	-	1 D Yes 2 No 27. Manner of Death	Hospital: 1 Inpatie	y 28	b. Time of	28c. Injur	y at		5 Residen			)
101	sndin aath. or: Aft he fun	atio	1 □ Natural 5 □ Pending 2 Accident investigation	, ,	2005	Injury 1030	O M 1□	Yes 2XN	vo 7	Fall			
DIVISION	or Attending Physician: tter death. Director: After this certific in by the funeral director,	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	building, etc	(Specify)				28f. L	City or Town.	Stațe)		Route Number,
	ours a ours a ours a filled		29a. Certifier 17 Certifying Ph	nysicien: To the best of		100 C		ne date and	d place and o	13 H		5+.	atad
:	To the Hospital or Attsndi within 24 hours after death.  To the Funeral Director: A compistely filled in by the fu	Medical	(Check only 2 Medicel Exer	niner: On the basis of and manner sta	examination	and/or inv	estigation, in my o	pinion, death	th occurred at	t the time, dat	e and place,	and due to	the cause(s)
1	Tot Tot	Σ	29b. Signature and title of certifier	1 Ott un			29c. Licens	e number	1-		I. Date signe	1	ay, Year)
,	01	-	p fext H/A	a KII MS		ysica				52	+		
V	)		30. Name and address of person who	Completed cause of de	1	a) (Type, I	Print)	RNR	St	Balti	more	M.	21201
	Sta	te	31. Date filed (Month, Day, Year)	32. Registra	Signature	20	F. D	8	`			1	
	Registr	ar	APR	2 5 2005 2	Marie S	A STATE	AND STATE OF THE S	7					

			1- State Amend Item 20th	State of Marylar per fh G842						•	138	58
	Physicia /Medio		1. Decedent's Name (First, Middle, Last) Charles S.	Lofton				2. Date of Dea Month		Year 2005	3. Time of D 9/50	PM PM
	Examin		4a. Facility Name (If not institution, give s Good Samari han	Hospital		4b. City, To	wn, or Location of De	ath	4c. 6	County of Death	re.	
	Funeral Director		5. Social Securify Number 6. Sex		last birthday) 38 Yrs.	If Under 1 Months D			1 191	9. Birth	place (State or F	Foreign
	aryland show	Ŀ	Usual Residence of Decedent  10a. State 10b. County		ty, Town or Lo				/ -	T	10d. Inside City	
	or 28e-f	Funeral Director	10e. Street and Number		ltimore	10f. Zip Ci			_	en of What Cou	4	
	death w	nerai	1705 Cliftview P	2. Was Decedent Ever in U Armed Forces?	J.S. 13.	Was Deceden	it of Hispanic Origin? Cuban, Mexican, Pu	(Specify Yes or No-	USA 1	4. Race - Ameri Black, White,	can Indian,	
0000	72 hours eller death with the Maryland natural, or Items 23a or 28a-f show Sical Examinat must be notified at	by	1 Never Married 2 Married 3 Widowed 4 Divorced	1 / Yes 2 No KYes, Give Year or Dates:		1 □ Yes 2	/	ono moan, etc.)	5	Specify: 6/0		
7.017	vithin 72 h ne. hen "natu e Medical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		(Give	dent's Usual C kind of work DO NOT use triciar	done during most of v retired)	vorking	16b. Kin	d of Business/In	dustry	
	permit. Pages 1 and 2 should be filed within 72 hours effer death with the Marylan Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene. Introportant: if them 27 is marked other than "natural; or items 23a or 28e-f show any injury or other traumatic svent, the Medical Examinal must be notified at ODGE.	Be	17, Father's Name (First, Middle, Last) Willie Lofton		Lieu	TI TOTAL		lame (First, Middle, M Taylor	Maiden S	Sumame)		
lary	and 2 should be saith and Mentai n 27 is marked o	To	19a. Informant's Name/Relationship (Typ. Craig LOFfon - Son	pe, Print)	19b. Maili	ing Address (S	Street and Number or		_	Town, State, Zip	Code)	
ש	Pages 1 ar nent of Hea int: If Item iry or other		20a. Method of Disposition  1 Burial 2 Cremation 3 R	emoval from State	cemetery, cre	osition (Name matory or othe	of proface) 5-2	-05°		ation - City or To		
Бапттог	permit. Po Departme Important any Injury pncs.		21. Signatur Funeral Service Laborase		Dutus 1		Address of Facility	170 Fredh	1400			12.10
H	EE!		23a. Part1 Enter the disease, or complishock, or heart failure. List only on	cations that caused the dea e cause on each line.		ter the mode of	of dying, such as card			puss Cal	Approximate Interval Betwee Onset and De	een
-14	Physician /Medical Examiner		Immediate/Cause (Final disease or condition resulting in death)	Due to (or as a conse		Acido						
4	1,000	liner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse	quence of):	Bou	sel					
ρΩ,	eath certificate be executed attending physician and for use as the burial-transit	al Examiner	that initiated events resulting in death) Last	Due to (or as a conse	quence of):							
200	certificate Iding phys	0	IF FEMALE:	3c. If yes, outcome of pregr								
מ	0 0	Physician/Medi	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown	1 Vest outcome of pregr 1 Live birth 2 Fet 4 Pregnant at time of 9 Unknown	ai death 3(	□Ectopic preg □ Other (spec			2;	3d. Date of deliv Month	ery Day Ye	ar
	w requires that the been signed by the should be detache	d by Ph	Part II. Dther significant conditions con Chronic Obsi	ructive Pu	ulmona	underlying cau	se given in Part I.			se contribute to t		
ပ္မ	The law req ite has beer bage 2 shou	Completed by	Congestive	Heart Fai	lure				rmed?	24b. Were auto prior to co death? 1 \( \subseteq Yes	opsy findings av	railable ise of
Vitai	Physician: The law rthis certificate has t ral director, page 2 s	Be	25. Was case referred to medical examiner?	ospital:			0.0	1 X Yes Death (Check only o	ne)			
	ng Phy fter this neral d	on: To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		4 ☐ Nursing Injury at Work?	g Home 5 Resid			fy)	
Division	or Attending P ifter death. Director: After in by the funera	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At I building, etc. (Spec	nome, farm, si	М	1 ☐ Yes 2 ☐ No	28f. Location (S City or Tox		Number or Run	al Route Numbe	97,
٦	To the Hospitel or Attendi within 24 hours after death.  To the Funeral Director: A completely filled in by the fu	edical Ce	29a. Certifier 12 Certifying Physical Check only one!	sician: To the best of my kner: On the basis of examinand manner stated.	nowledge, dea nation and/or in	th occurred at	the time, date and pla my opinion, death of	ace, and due to the courred at the time,	cause(s) a	and manner as s place, and due t	stated. o the cause(s)	
	To the Comple	Med	29b. Signature and title of certifier	Wall	- M.	_	ES-000			signed (Month,		-
7	9		30. Name and address of person who co	impleted cause of death (Ite					. / [			
	Sta Regist	ate	30. Name and address of person who come had been addressed and address of person who come had been addressed and address of person who come had been addressed and address of person who come had been addressed and address of person who come had been addressed and address of person who come had been addressed and address of person who come had been addressed and address of person who come had been addressed and address of person who come had been addressed and address of person who come had been addressed and address	32. Registrar's Sid	iature	H A	ostil	1 10 2.12	د ر			

Lindemon, Matherine

	Please	Type or Print	in Black In	delible Ink	. Ensure	All Copies	s Are Legi	ble.
F		State of Mai	vland / Dep	artment of H	lealth and	Mental Hy	giene	-
For State Registrar			-	rtificate of			Reg. No.	15   3859
Decedent's Name	e (First, Middle, La	ast)				2. Date of D		3. Time of Death
Katherin		н.	I	indemon		Month D4/-	Day	Yeer 12,15-PM
4a. Facility Name (/	f not institution, giv	ve street and number)		4b. City, Town, o	or Location of Dea	ith	4c. County	of Death
Franklin 5. Social Security N 213-36-30		HUSPITA/ (Sex 7. Age 1 M 212) F	(In yrs. last birthday, 68 Yrs.	Months Days	If Under 24 Hr. Hours Min		Ba 1 ith ay, Year) 1936	9. Birthplace (State or Foreign Country) MD•
Usual Residence of								
10a. State	10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
MD.	Baltim	ore	Dundal	.k				1 ☐ Yes 2 ☐XNo
10e. Street and Nur 118 Brian		.đ		10f. Zip Code 21222	2		10g. Citizen of V USA	Vhat Country?
11. Marital Status		12. Was Decedent Ev Armed Forces?	ver in U.S. 13.	Was Decedent of H	Hispanic Origin? (	Specify Yes or N	o- 14. Raci	e - American Indian,
1 Never Marri	ed 2 Married	1 Tes 2XXNo				no Alcan, etc.)		k, White, etc.
3X Widowed	4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 XNo	Specify:		Specify	White
(Spec	15. Decedent's E ify only highest gr	Education rade completed)	(Give	edent's Usual Occup e kind of work done DO NOT use retire	during most of we	orking	16b. Kind of Bu	siness/Industry
Elementary/Seco	ndary (0-12)	College (1-4or 5+	)				D- 144	Country
12 years			Scho	ol Bus Di		.=		more County
17. Father's Name	(First, Middle, Las	t)				,	e, Maiden Sumam	е)
Jack Char	les Howe				Matilda	a Borman		
19a. Informant's Na Brenda Da		(Type, Print) Daughte		ing Address (Street Briarwo			per, City or Town, , Md. 21	
		□Removal from State		osition (Name of imatory or other pla Memoria	_	ril 25, 2005	20c. Location - Parkvil	City or Town, State
21. Signature of Fu	home	( onnel		2. Name and Addre Connelly 1 110 Solle	וח וסט פרב	r koad.	Diinga i K.	P.A. Md. 21222
23a. Part1. Enter t	he disease, or con	nplications that caused the	ne death. Do not en	ter the mode of dyi	ng, such as cardia	ac or respiratory	arrest,	Approximate Interval Between
Immediate Cause disease or condition resulting in death)	(Final	. Metas	tatic B	reast (				Onset and Death  Luce KS
Sequentially list co if any, leading to in cause. Enter Unde Cause (Disease or that initiated events	imediate injury	b. Due to (or as a	consequence of):					
resulting in death)		Due to (or as a	consequence of):					
IF FEMALE: 23b. Was deceden in the past 12 1  Yes 25 9 Unknown	months?	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at ti 9 ☐ Unknown	Fetal death 3	□Ectopic pregnanc	у		23d. Dat Mor	e of delivery nth Day Year

Pnysician /Medical Examiner

Physician/Medical Examiner

Director

Be Completed by Funeral

0

**Physician** 

/Medical

Examiner

Funeral

Director

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "paturel", or Items 23a or 28a-1 show any injury or other treumetic event. Ite Mcdcal Examination at the notified at once.

ed by the attending physician and detached for use as the burial-transit

Be Completed by

Medical Certification: To

The law requires that the death certificate be executed within 24 hours after death. To the Funerel Director: After this certificate has been signed by I completely filled in by the funeral director, page 2 should be detact To the Hospitel or Attending Physician:

Division of Vital Records, P.O. Box 68760,

Precimonia

1 Yes 2 No

27. Manner of Death

1 Natural

2 Accident

3 Suicide

4 | Homicide

25. Was case referred to medical examiner?

29b. Signature and title of certife

rear

1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed?

2 No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Cther: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

1 Yes

Date of Injury (Month, Day Year) 28b. Time of

28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1/X Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

5 Pending investigation

6 Could not be

determined

29c. License number

29d. Date signed (Month, Day, Year)

completed cause of death (Item 23a) (Type, Print)

H0060576

State

32 Registrar's Signature egne 31. Date filed (Month Day, 2 5 2005 Descer.

Franklin Square Drive 90

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.-2. Pate of Death 1. Decedent's Name (First, Middle, Last) **Physician** 22:14 Annie Mae Lewis /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 8. Date of Birth (Month, Day, Year) 06/22/1932 9. Birthplace (State or Foreign Country)
S. Carolina 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Min. 1□M 2₩F 577-44-1410 Yrs. Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits rel', or items 23a or 28a-f shov Examiner must be notified at X□Yes 2□No Completed by Funeral Director MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3701 North Rogers Avenue 21207 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2★ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 🎾 No Specify: Black 3 Widowed 4 □ Divorced Specify. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4or 5+) 1 and 2 should be filed with Health and Mental Hygiene. 11th Cook Baltimore City 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be marked Vallie Jones Rose Marion 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health Iem 27 Donnell Lewis - Son 3701 North Rogers Avenue; Baltimore, MD 21207 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ŏ United the second state of the second state of the second 4/18/05 King Memorial Cem Windsor Mill, MD 22. Name and Address of Facility Freeman Funeral Services 21. Signature of Funeral Service Licensee any in P.O. Box 416; SUitland, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or flear failure. List only one cause on each line. Approximate Interval Between Onset and Death mmediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine anding physician and use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. | 1 ☐ Yes 2 ☐ No. 9 Unknown 9 Unknown been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an Were autopsy findings available prior to completion of cause of autopsy perform death? 21 No 2[ the Hospitel or Attending Physician: Be 25. Was ca e 26. Place of Death (Check only one examiner? Other: 2 No 2 1 npatient 1 🗌 Yes 2 ER/Outpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 3□ DOA var er of leath 1 Natural Dite Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 ☐ Yes 2 ☐ No hours after death. Accident within 24 hours after death To the Funerel Director: 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of contine 29 Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

30. Name and address of person who com leted cause of death (Item 23a)

2005

31. Date filed (Month, Pay, Year)

APR 25

Howard Lewis Lemaster amend Transport of Print in Black Indelible 13k of Figure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 05-02764 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Yeer **Physician** Howard Lewis Lemaster April 20 2005 07:44 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore East Pontiac Avenue 1300 Block of If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 06/18/1941 7. Age (In yrs. last birthday) 5. Social Security Number Birthplece (State or Foreign Country) **Funeral** Days Hours Months 236-62-5569 1⊠M 2□F 63 Maryland Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits th and Mental Hygiene. 27 is marked other than "natural", or items 23e or 28e-f show treumatic event, the Madical Examinar mast be notified at Baltimore MD N/A1 Yes 2 No Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1324 Pontiac Avenue 21225 U.S.A. death Funera Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status be filed within 72 hours after dital Hygiene. diother than "natural", or Item ☐Yes 2 No Yes, Give 1 ☐ Never Married 2 € Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: Specify: White Completed by 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Self Employed Home Improvement 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be George Edward Lemaster Lula Virginia Davis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
Department of Health at importent: If item 27 is any injury or other treu. 1324 Pontiac Avenue Baltimore, Maryland 21225 Reba Lemaster 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 K Removal from State Rosedale 4/24/05 Martinsburg WV. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Miller-Dippel Funeral Home Inc. 21. Signature of Eugeral Service Licenses 6415 Belair Road Baltimore, Maryland 21206 23a. Part1. Enter the disease, or combinations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Compressional asphyxia and chest injuries disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): The law requires that the death certificate be executed use as the burial-transi resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 attending physician Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy ŏ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4 Pregnant at time of death 5 Other (specify) should be detached 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy performed? death? Yes 2□No 2 No director, 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence Worther (SpecifyAt Scene ٩ 1 ¥ Yes 2 □ No 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury , (Month, Day Year) 28c, Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: or Attending Injury 1 Natural 5 Pending Found 44 AM 20/05 within 24 hours after death. To the Funeral Director: A 1 Yes 2 No subject pinned between two vehicles Accident investigation the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide 1300 block Pontius Ave, Baltimore, MD treet To the Hospital 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number miD OCME April 20, 2005 a 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street Baltimore, Maryland 21201 LING 31. Date filed (Month, Day, Year) **F**egistrar's Signature State APR 25 2005 Registrar DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene

			1 - State Registrar		Cei	rtificate of t	Death		Reg. No		
	Physici /Medic		1. Decedent's Name (First, Middle, Las Elizabeth F. Ma	·				2. Date of D Month		20 45	3. Time of Death
	Examir		4a. Facility Name (If not institution, give				Location of Deat	h		County of Death	n/a
ľ	Funeral Director		5. Social Security Number 6. S 212–12–0321		last birthday) Yrs.	If Under 1 Year Months Days			ay, Year)	Coun	lace (State or Foreign try)
	the Maryland 28a-f show notified at	ctor	Usual Residence of Decedent  10a. State  Maryland  Baltimo		y, Town or Lo Cato	ocation onsville				1	0d. Inside City Limits 1 ☐ Yes 23€ No
	uth with the 23a or 28	al Director	10e. Street and Number 51 N. Belle Grove	Road		10f. Zip Code 2122	8			izen of What Cour lited Sta	-
920	after des or Items	by Funeral	11. Marital Status  1 Never Married 2 Married 3 SWidowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	ispanic Origin? (S an, Mexican, Puerl Specify:	pecify Yes or N to Rican, etc.)	0-	14. Race - Americ Black, White, Specify: W	
21215-0036	within 72 hours ene. than "netural", the M. viral Ex.	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	lucation de completed) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done o DO NOT use retired	durina most of wo	rking	16b, K	ind of Business/Ind	dustry
	should be filed within the Mental Hygiene. s marked other than umatic event, the Mental than the Mental than the Mental than the Mental than Mental th	To Be Con	17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Sur								Home
, Maryland	1 and 2 shou Health and M tem 27 is mari		John W. Mahlstedt	, III/Grandson	110 E	Flanagan 1		aneytow	n, Ma	ryland 2	1787
Baltimore,	Page ment o ent: If ury or		20a. Method of Disposition  1 XBurial 2 Cremation 3   4 Departion 5 Other (Specify 21 Signatur) of Funeral Service Licer	Removal from State	emetery, crei udon P	osition (Name of matory or other place ark Cemet 2. Name and Addre	ery 4/22		Bal	timore, N	Maryland
B	permit. Departi		23a Part Flier the disease or com	plications that caused the death	4	1107 Wilke	ens Aven	ue, Balt	imor		and 21229
	Priysician /Medical		23a. Part1. Enter the disease, or com, shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a conseq	mic		y, such as caldiar	on respiratory :	arrest,		Interval Between Onset and Death
	executed in and ial-transit	/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Course Underlying Course Underlying Course Underlying Course (Underlying Course) (U	cause. Enter Underrying Course [List asset of white] that initiated events  C.							
68760,	certificate be executed ding physician and se as the burial-transit	edical		d							
P.O. Box	death e atten ed for u	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	I death 3[	Ectopic pregnancy Other (specify)				23d. Date of delive Month	ry Day Year
	0 0	ed by Pl	Part II. Other significant conditions of	ontributing to death but not res	ulting in the u	nderlying cause giv	en in Part I.			use contribute to th	e cause of death?
of Vital Records,	The ate h page	Completed by	ATRIAL FIBE	HUATION				24a. Wa auto perf 1 \sum Yes	s an opsy ormed? 2 No	death?	osy findings available inpletion of cause of 2 No
Vita	Physician: The rathis certificate har all director, page	Be	25. Was case referred to medical examiner?	Hospital: 1 ☐Inpatient 2 ☐		oth Oth	26. Place of Dea				
Division of	ing Ph I. After th funeral	atlon: To	27. Manner of Death  1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time or Injury	f 28c. Injur	4 🗆 Nursing F	28d. Describe		6 ⊡Other ( <i>Specif</i> y ry occurred	7)
Divis	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	building, etc. (Specify	y) 			City or To	wn, State		
	ne Hospital n 24 hours a ne Funeral bletely filled	Medical	29a. Certifier 1 Certifying Ph (Check only 2 Medical Exam	ysician: To the best of my kno niner: On the basis of examina and manner stated.	wledge, deat tion and/or in	h occurred at the tin vestigation, in my o	ne, date and place pinion, death occu	and due to the irred at the time	cause(s) , date and	and manner as st place, and due to	ated. the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier    Woundark   N.D.	WRTAZA KAZ	Mi, M	29c. Licens	7610.		29d. Da	te signed (Month, I	Oay, Year) <b>∂0 %</b> .
	1		30. Name and address of person who MURTALA KAZWI,	completed cause of death (Item	23a) (Type,	Print)	ST. AGNES	HOLPIT	AL,	BALTIMOR	card an , s
:-	Sta	ate	31. Date filed (Month, Day, Year)	2. 5. Registrar's Sana 2. 5. 2005	iture	Hi do	<i>.</i>				

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		•	1 - State of Maryland / Dep	ertificate of Death	Reg.	2005 10050
	Direction.		Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year 3. Time of Death
	Physicia /Medic		Frank A. Murray		April 17	
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
			Joseph Ritchie Hospice	Baltimore		n/a
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	/) If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Ye	9. Birthplace (State or Foreign Country)
	Director		214-03-5195 12 M 2 F 94 Yrs.	1	Oct 20,	1910 Maryland
	pu 💌	}	Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or I	conting		10d locids City Limits
	aryla shov	-				10d. Inside City Limits 11☑ Yes 2 ☐ No
	8a-f	ctc	Maryland n/a Baltimo		-1	
	or 2	Director	10e. Street and Number	10f. Zip Code	10g.	. Citizen of What Country?
	be filed within 72 hours after death with the Maryland tal Hyglene d other than "netural", or iteme 23a or 28a-f show event, the Medical Everal, art miss be notified at	<u>ra</u>	3651 MacTavish Avenue	21229		USA
	teme	Funerai	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	<ul> <li>Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto</li> </ul>	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.
9	or i	by Fi	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give → 3 ☑ Widowed 4 ☐ Divorced Year or Dates:	1 ☐ Yes 2X No Specify:		Specify: White
215-0036	urai'					
Ÿ	"net	Completed	(Specify only highest grade completed) (Giv	edent's Usual Occupation re kind of work done during most of work DO NOT use retired)	ing 16t	b. Kind of Business/Industry
	withir ne.	E D	Elementary/Secondary (0-12) College (1-4or 5+)	,		Manual at
7.7	filed v Hygie other 1	ပိ	17. Father's Name (First, Middle, Last)	intenance	e (First, Middle, Mai	Manufacturing
Maryland	m - 0 5	Be	Frank A. Murray		ne Ripkin	den Sumame)
₹	should be nd Mental marked o	To				
<u>a</u>	permit. Pages 1 and 2 should be Department of Health and Menta Important: if item 27 ie marked any injury or other treumatic es once.			ling Address (Street and Number or Rui		
<u>~</u>	and ealth m 27			1 MacTavish Avenue	The state of the s	
altimore,	of H of H if ite		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State  20b. Place of Disposition cemetery, cr	position (Name of ematory or other place)	Date 200	c. Location - City or Town, State
Ē	Pag ment ant: ury c			Park Cemetery 4/22	/05 Ba	altimore, Maryland
<u>a</u>	sparti sparti sport sport sy inj		21. Signature of Funeral Service Licensee	22. Name and Address of Facility H	ubbard Fu	neral Home, Inc.
m	89 2 2 2		Kihal Broke			ore, Maryland 21229
			23a. Part1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between
	Physician			RATIVE DISEASE	1.00	/ Opent and Death
	/Medical		disease or condition resulting in death)  a	VIJII- DISEITIE	100 72 2	01) 430 2030
	Examiner		Sindrome	)		
		ē	if any, leading to immediate Due to (or as consequence of):	/		
1	uted d ansit	Examiner	causé. Enter Underlying Cause (Disease or injury that initiated events c.			1
	al-tra	Exa	resulting in death) Last  Due to (or as a consequence of):			
58760,	icate be executed physician and s the burial-transit	al				
289		edical	y			
×	The law requires that the death certific ate has been signed by the attending page 2 should be detached for use as		IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of delivery
Вох	atter for u	Physician/M	in the gast 12 months?	☐ Ectopic pregnancy ☐ Other (specify)		Month Day Year
o.	the d y the ched	ıysı	9 Unknown			
٥.	that ed b		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobac	cco use contribute to the cause of death?
d S	sign d be	d by	DUT ILL Drawones sept	i cenia	1 ☐ Yes	2 No 3 Probably 4 Nunknown
Ö	w require been sig should b	ete	O T I I t			
Records,	elaw hasl	ldu	Jancy Dent, Therention		24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of death?
	The ate	Completed			performed 1☐ Yes 2 <b>亿</b>	
	() .		25. Was case referred to medical examiner?		h (Check only one)	
	cien: ertific actor.	Be				- attour and Harmon
	hysicien: Th his certificate il director, pag		1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpati		me 5∐Residenc	e 6 Douther (Specify)
	ng Physiclen: fter this certific ineral director,	To B	1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpati 27. Manner of Death 28a. Date of Injury 28b. Time	of 28c. Injury at	ome 5 ☐ Residence 28d. Describe how	
	ending Physiclen: sath. or: After this certific he funeral director.	To B	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpati  27. Manner of Death 1 Natural 5 Pending 2 Accident Accident Services (Month, Day Year)  1 Accident Services (Month, Day Year)	ent 3 DOA 4 Nursing Ho		
	r Attending Physicien: er death. rector: Atter this certific by the funeral director.	To B	1 ☐ Yes 2 ☑ No	of 28c. Injury at Work?  M 1 Yes 2 No	28d. Describe how	injury occurred at and Number or Rural Route Number,
Division of Vital F	itel or Attending Physicien: rs after death. el Director: After this certifice ed in by the funeral director.	Certification; To B	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpati  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined.	of 28c. Injury at Work?  M 1 Yes 2 No	28d. Describe how 28f. Location (Stree	injury occurred at and Number or Rural Route Number,
	ospitet or Attending Physicien: hours after death. unerel Director: Atter this certific ily filled in by the funeral director.	Certification; To B	1 Yes 2 No  1 Inpatient 2 ER/Outpati 27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide  28a. Date of Injury (Month, Day Year) 28b. Time (Month, Day Year) 28b. Time (Month, Day Year) 28c. Place of Injury - At home, farm, so building, etc. (Specify)  29a. Certifier  1 Certifying Physician: To the best of my knowledge, day	of 28c. Injury at Work?  M 1 Yes 2 No  street, factory, office	28d. Describe how 28f. Location (Stree City or Town, S	injury occurred  at and Number or Rural Route Number, State)  se(s) and manner as stated.
	the Hospitel or Attending Physicien: in 24 hours after death. The Funerel Director: After this certific pletely illied in by the funeral director.	Certification; To B	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpati  27. Manner of Death 1 DNatural 5 Pending 2 Accident investigation 3 Suicide 4 Homicide	of 28c. Injury at Work?  M 1 Yes 2 No  street, factory, office	28d. Describe how 28f. Location (Stree City or Town, S	injury occurred  at and Number or Rural Route Number, State)  se(s) and manner as stated.
	ing Phys After this Ineral di	To B	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpati 27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide  28a. Date of Injury (Month, Day Year) 28b. Time Injury 28b. Place of Injury - At home, farm, second in the building, etc. (Specify)  29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or	of 28c. Injury at Work?  M 1 Yes 2 No  street, factory, office  ath occurred at the time, date and place, investigation, in my opinion, death occur	28d. Describe how  28f. Location (Stree City or Town, Street and due to the cause and at the time, date	injury occurred  at and Number or Rural Route Number, State)  se(s) and manner as stated.
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.	Certification; To B	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpati 27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 4 Homicide 29a. Certifier (Check only one)  28a. Date of Injury 28b. Time (Month, Day Year) 28b. Time (Month, Day Year) 28b. Place of Injury - At home, farm, suitiding, etc. (Specify)  28b. Place of Injury - At home, farm, suitiding, etc. (Specify)	of 28c. Injury at Work?  M 1 Yes 2 No  street, factory, office  ath occurred at the time, date and place, investigation, in my opinion, death occur	28d. Describe how  28f. Location (Stree City or Town, Street and due to the cause and at the time, date	et and Number or Rural Route Number, state)  se(s) and manner as stated. and place, and due to the cause(s)
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	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.	Certification; To B	1 Yes 2 No  1 Inpatient 2 ER/Outpati 27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide  28a. Date of Injury (Month, Day Year) 28b. Time Injury 28b. Place of Injury - At home, farm, selection of the building, etc. (Specify)  29a. Certifier (Check only one)  29b. Signature and title of certifier  20c. Hospital: 1 Inpatient 2 ER/Outpati 28a. Date of Injury (Month, Day Year) 28b. Place of Injury - At home, farm, selection of the basis of examination and/or and manner stated.	of 28c. Injury at Work?  M 1 Yes 2 No  street, factory, office  ath occurred at the time, date and place, investigation, in my opinion, death occur  29c. License number  D D 22 5 0	28d. Describe how  28f. Location (Stree City or Town, S  and due to the caus red at the time, date	et and Number or Rural Route Number, state)  se(s) and manner as stated. and place, and due to the cause(s)
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.	Medical Certification; To B	1 Yes 2 No  1 Inpatient 2 ER/Outpati 27. Manner of Death 1 No Natural 2 Accident 3 Suicide 4 Homicide  28a. Date of Injury (Month, Day Year) 28b. Time (Month, Day Year) 28b. Time 28b. Place of Injury 28c. (Specify)  28c. Place of Injury - At home, farm, shoulding, etc. (Specify)  29a. Certifier (Chack only one) 29b. Signature and title of certifier  30. Name and address of person who completed cause of death (Item 23a) (Typ)	of 28c. Injury at Work?  M 1 Yes 2 No  street, factory, office  ath occurred at the time, date and place, investigation, in my opinion, death occur  29c. License number  D D 22 9 0  e. Print)	28d. Describe how  28f. Location (Stree City or Town, S  and due to the caus red at the time, date	et and Number or Rural Route Number, state)  se(s) and manner as stated. and place, and due to the cause(s)

			For State Registrar	State of M	arylanc		artment rtificate			and M		giene Reg. No.	005	139	351
	Physici		1. Decedent's Name (First, Middle, La Bilal Malik	st)							2. Date of Dea		005 Year	3. Time of 6:57	Death P
	/Medic Examir		4a. Facility Name (If not institution, giv UNIVERSITY OF MAR			TR	BA	LTIM	Location o	CITY			ounty of Death		
	Funeral Director		213-78-2755	Sex 7. Ag	ge (In yrs. Ia 45	st birthday) Yrs.	If Under Months	1 Year Days	If Under: Hours	Min.	8. Date of Birt (Month, Day 06-14-19	y, Yeer)	9. Birth Cou Mary	place (State on htry) Land	r Foreign
	aryland show	2	Usual Residence of Decedent  10a. State 10b. County  MD NA		10c. City,	, Town or Lo	cation	'Δ						10d. Inside Ci	ity Limits
	or 28a-f	Director	10e. Street and Number		.[		10f. Zip					10g. Citize	n of What Cou	ntry?	
036	s 1 and 2 should be filed within 72 hours efter death with the Maryland Health and Mental Hygiene Item 27 is marked other than "natural", or Items 23s or 28s-1 show other traumatic event, the Medical Evant or must be notified at	by Funerai	600 Walmut Grove Road  11. Marital Status  1   ↑ Never Married 2   → Married  3   → Widowed 4   → Divorced	12. Was Decedent Armed Forces 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:	?		Was Deced If Yes, spec	ent of His	221 spanic Origin, Mexican Specify:	gin? (Spe i, Puerto I	ocify Yes or No- Rican, etc.)		A Race - Ameri Black, White, pecify: Black	etc.	
Maryland 21215-0036	e filed within 72 ho al Hygiene. I other then "natur vent, I o Medical	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)		5+)	16a. Deced (Give life.	dent's Usua kind of wor DO NOT us Driver	k done d e retired)	tion uning most	t of workin	ng		of Business/In	dustry	
yland 2	2 should be filed and Mental Hygi Is marked other surmatic event, I	To Be C	17. Father's Name (First, Middle, Last Joseph Williams						Lando	onia J	(First, Middle,			Codel	
	s 1 and 2 show the stand t		19a. Informant's Name/Relationship ( Peggy McCray-Jenkins, 20a. Method of Disposition	/Sister	CO		alnut G	rove	Road I	Issex,	MD 2122	1	tion - City or T		
Baltimore,	permit. Pages Department of H Importent: If Ite any injury or of		1 Ø Surial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	(y)		Memori 22	al Par	k d Addres	s of Facilit		-05 N. Gilmor		allstown		-
8760,	Physician physician and physician and physician and physician and physician and the physician and physician and physician and physician and physician and physician ph	dicai Examiner	23a. Part1. Enter the disease, or comshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last		SIS a conseque	ence of):	er the mode	e of dying	, such as	cardiac o	r respiratory ar	rest,		Approximat Interval Bet Onset and I	ween
P.O. Box 6	death certifii e attending I ad for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal	death 3	Ectopic pro					230	d. Date of deliv Month		Year
	w requires that the been signed by the should be detache	by	Part II. Other significant conditions of	contributing to death I		Iting in the u	nderlying ca	ause give	n in Part I. EMA	<u>_</u>	23e. Did to		contribute to t No 3 ☐ Pro		death? Unknown
l Reco	The la ete has page 2	Completed	FAILURE								24a. Was autop perfo	an an an an an an an an an an an an an a	24b. Were auto prior to co death? 1 \( \subseteq \text{Yes}		available ause of
n of Vital Records,	ding Physiclen: Th n. Atter this certificate funeral director, pag	To Be	25. Was case referred to medical examiner?  1 □XYes 2 □ No  27. Manner of Death 1 □XNatural 5 □ Pending	Hospital: 1 Inpati	игу	ER/Outpatier 28b. Time o Injury		Othe 8c. Injury Work	<sup>©</sup> 4 □ Nu	rsing Hor	n (Check only o me 5 ☐ Resid 28d. Describe h	ience 6		fy)	
Division	or Attenoiter death	Certification:	2 Accident investigatio 3 Suicide 6 Could not b 4 Homicide determined	28e. Place of In	jury - At hor tc. (Specify)	me, farm, str	M reet, factory		′es 2□		28f. Location (S City or Tow		Number or Run	al Route Num	ber,
	the Hospitel hin 24 hours e the Funeral i	edical	29a. Certifier 1 Certifying PI (Check only one) 2 X Medical Exer	hysician: To the best miner: On the basis of and manner s	of examinati	vledge, deatl ion and/or in	vestigation,	, in my op	inion, dea	d place, a th occurre	ed at the time,	date and pl	ace, and due t	o the cause(s	;)
)	To the within 2 To the complet	Σ	29b. Signature and title of certifier	•				: License	number				_ 21, 2		
-	1			BIO, MD				111	Penn	Stre	et Bal	timor	e, Mar	yland :	21201
	Sta Regist		31. Date filed (Month, Day, Year)	32. Regist	radis Signati	ure	100	de							

DHMH 17 Rev 1/2001

ORIGINAL

				nent of Health and M cate of Death	lental Hygie		13865
	Physic /Medi Examir	cal	Myron David Watthies	City, Town, or Location of Death	2. Date of Death Month	Day Year  is 2005  4c. County of Death	3. Time of Death 9:05 p M
	Funeral Director	lei	Shady Grove-Potomac Valley Murany  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) It U	ROCKULILE Under 1 Year If Under 24 Hrs. nths Days Hours Min.	8. Date of Birth (Month, Day, Y	montgome	e (State or Foreign
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If itam 27 is marked othar than "natural", or Itams 23a or 28a-f show any injury or othar traumatic evant, If e M-dical Examinatibe rotilised at once.	To Be Completed by Funeral Director	3   Widowed 4   Divorced   If Yes, Give Year or Dates:   1   Yes   Year or Dates:   1   Yes   Year or Dates:   1   Yes   Year or Dates:   1   Yes   Year or Dates:   1   Yes   Year or Dates:   1   Yes   Year or Dates:   1   Yes   Year or Dates:   1   Yes   Year or Dates:   1   Yes   Year or Dates:   1   Yes   Year or Dates:   1   Yes   Year or Dates:   1   Yes   Year or Dates:   1   Yes   Year or Dates:   1   Yes   Year or Dates:   1   Yes   Year or Dates:   1   Yes	M. Zip Code  20850  Decedent of Hispanic Origin? (Sp., specify Cuban, Mexican, Puerto des 22 No Specify:  Usual Occupation of work done during most of work of work done during most of work of use retired)  18. Mother's Name  Chado  dress (Street and Number or Rura Stitution Blvd.	ecity Yes or No-Rican, etc.)  ing  16  A (First, Middle, Ma  THE Jo  Al Route Number, Co  Date 20  1 28, c5 Cc	14. Race - American Black, White, etc.  Specify: White b. Kind of Business/Indus  exartment  iden Sumame)  iden Sumame)  iden Sumame)  chnKE  ity or Town, State, Zip Co	Indian,  Store  ode)  508  , State
	Physician /Medical Examiner pural-transit	Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, feating to infimediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):	mode of dying, such as cardiac of	or respiratory arrest	, Ar	21307 oproximate terval Between nset and Death
P.O. Box 68760	that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	Physician/Medical	11345	pic pregnancy or (specify)		23d. Date of delivery Month Da	y Year
Vital Records, P	The law requires ate has been sign page 2 should be	e Completed by Ph	Endstage Rend Diser > H Anemia , Diabeta Mellite	type/fension	1  Yes  24a. Was an autopsy performed 1 Yes 2	24b. Were autopsy prior to comple death?	y 4 Unknown findings available etion of cause of
of	hys this al dii	Certification: To Be	examiner?  1   Yes 2   ZNo	28c. Injury at Work?	ne 5  Residence 28d. Describe how i		The state
Div	Hospital or 4 hours afte Funaral Dir ely filled in I	edical Certifi		rred at the time, date and place, a	City or Town, S	e(s) and manner as date	
) (	To that within 2 To that complete	Med	29b. Signature and title of certifier	29c. License number  10060036		Date signed (Month, Day	
	) Sta	te	31. Date filed (Month, Day, Year) 32/Registrar's Signature	if Grove R	ocknij	ie, MD	
	Registr	ar	APR 2 5 2005 Been & Aprile	1			

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year **Physician** Malbrough April 21, Geneva 2005 3:20 a /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Westminster Nursing Home Westminster Carrol1 If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 WV 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 ☐ M 2 🖾 F Yrs. 79 Director 220-20-3640 19, Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. The Transke and Mental Hygiene. The Transke of the Than and Transke and the Transke overly the Marylest Experimentic event, the Marylest Experiment be traffilled at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 🛛 No Carrol1 Finksburg Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2525 Baltimore Blvd. #22 21048 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify ģ 3 Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Retail 12 Sales Clerk permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked othe any injury or other traumatic evant 2008. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ပ Mildred Henson Clarence Lee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5324 Carroll Warehime Rd., Manchester, MD 21102 <u>Sidney E. Malbrough</u> Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Parkwood Cemetery 4/25/05 Baltimore, MD 1 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 11824 Reisterstown Road Eline Funeral Home Reisterstown, Maryland 21136 Sins 23a. Part1. Enter lie disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit S Due to (or as a consequence of) hed by the attending physician detached for use as the burial Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Dav Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy perform certificate 2 5 No 1 🗌 Yes 1 Yes 2 🗆 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 1 ☐ Yes 2 ☐ No 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Aftert Natural 5 Pending investigation М 1 ☐ Yes 2 ☐ No death. 2 Accident after death the 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \( \text{Homicide} within 24 hours a To tha Funaral L 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only опе and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) 25443 nd address of person who completed cause of death (Item 23a) (Type, Print) John Middleton 688 Poole Road 21157 Westminster, MD 31. Date filed (Month, Day, Year) 32. Rg State APR 2 5 2005 Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Meeks April 21 George /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BULLIMOVE Johns Hopkins Bayview Medical Center If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours Min. 1 X M 2 ☐ F Yrs. 216-32-9526 Director 69 April 12,1936 Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 28a-f show 10d. Inside City Limits ar than "netural", or items 23a or 28a-f shov The Modical Exprimer : ust be nutified at Director 1 ☐ Yes 2X No MD Baltimore Dunda1k 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death 3701 North Point Road #20 Completed by Funeral 21222 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 K Yes 2 □ No If Yes, Give Year or Dates: 1955-63 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 2 should be filed within 72 hours after or and Mental Hygiene. is marked other than "netural, or iter 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify: Specify: 3 ☐ Widowed 4 X Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Baltimore City Elementary/Secondary (0-12) College (1-4or 5+) Maintenance 6 Water Dept. or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should ပ Herman Meeks <u>Ann Voytko</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 of Department of Health an Important: if item 27 is an injury or other trauons. George H. Meeks, Jr. 38 Trevanion Road, Taneytown, MD 21787 Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Vet.Cem 4/26/05 Owings Mills, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 11824 Reisterstown Road Ling Eline Funeral Home Reisterstown, MD 21136 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each fine. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician a. Non small cell lung cancer YEAR ONE /Medical Due to (or as a consequence of): **Examiner** respirativy failure Sequentially fist conditions, I any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last FIVE DAYS Dhe to (or as a nonsequence of): Examine or Attending Physicien: The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetaf death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) P.0. the 9 Unknown 9 Unknown þ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an page 2 autopsy performed? 2 **X** No 1 Tyes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 ☑ No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 DOA After the tuneral 27 Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 W Naturaf death. 1 ☐ Yes 2 ☐ No 2 Accident atter death Director: pletely filled in by the 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a
To the Funeral D
Oompletelv filled 178 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medicai 29a. Certifier and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) mein Amule, mi) RES-000 21, APRIL 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOHN'S HOPKIN'S BAYVIEW MEDICAL CENTER 4940 EASTERN AUG BAUTIMORE MD 21224 Melissa Munsell 31. Date filed (Month, Day Year)
APR 2 5 2005 sistrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Yes Physician Year Samuel P. Massie Jr. April 3:50 a M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Mariner Health of Greater Laurel Laurel 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 02 M 2□ F Director 431-07-4797 Usual Residence of Decedent filed within 72 hours after death with the Maryland show 10b. County 10c. City, Town or Location 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Marylan and of Heath and Maralal Hygiens and the filed at 1 smarked other then "natural", or frems 23a or 28e-1 show any 1 item 2 to other treamstic event, if a Medical Examinar must be notified at 12 Yes 2 No Funeral Director Maryland Prince George's Laure1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20708 USA 12203 Brittanv Place 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Snecify: Specify: Black Be Completed by 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Chemist/ Professor 12th 10 yrs. US Naval Academy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Samuel P. Massie Sr. Earleigh Jacko 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Samuel P. Massie, III (Son) 12203 Brittany Place Laurel, Md. 20708 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Department of Important: If eny injury or once. \* 4 □ Donation 5 □ Other (Specify) St. Anne's Cemetery 4/16/05 Annapolis, Md. Wm. Reese & Sons Mortuary, P.A. 21401 21. Signature of Funeral Service Licensee Larry & Reese, MOO 483 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician SEIZURE DISORDER disease or condition resulting in death) MONTHS /Medical Due to (or as a consequence of): **Examiner** CEREBRO VASCULAR ACCIDENT 3-4 moniths Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physiclan/Medical Examiner Hospitel or Attending Physicien: The law requires that the death certificate be executed burial-transit HYPERTEN JON MEMILS Due to (or as a consequence of): the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4 Pregnant at time of death 5 ☐ Other (specify) Ö 9 Unknown ئە Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, FAILURE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown funeral director, page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death Check onl one Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA | Other: 4 | Nursing Home 5 | Residence 6 | Other (Specify) 1 ☐ Yes 2 No Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel D Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ATTENDING D0057216 APRIL 15, 2005 PHYSICIAN 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3450 RD, MEADE BAAKD m.D AUREZ an 20724 31. Date filed (Month, Day, Year) 2. Registrar's Signature APR 2 5 2005 Registrar

			1 - For State Registrer	ate of Maryland / Do		nent of H cate of L			giene Rag. No.	005	13869
	Physic /Medi		1. Decedent's Name (First, Middle, Last)  Edna Purvis Nelso	on				2. Date of De Month APr .	Day	Year 2005	3. Time of Death 9:20A M
	Examir		4a. Facility Name (If not institution, give stree 3 Pine Hill Court			City, Town, or Woodst	ock	Death	4c. (	County of Death Baltimo	pre
	Funeral Director		5. Social Security Number  207-07-0126  Usual Residence of Decedent	7. Age (In yrs. last birth	Mo	Inder 1 Year onths Days	If Under 24 Hours	Min. 8. Date of Bird (Month, Da March	y, Year)	9. Birth Cou 21 Penn	place (State or Foreign intry) ISYlvania
	e Marylan Be-f show diffed of	Director	10a. State 10b. County Pennsylvania Montgor	nery Willow							10d. Inside City Limits 1 ☐ Yes 2√2 No
	ath with the 236 or 2 unit by the	ral Dire	10e. Street and Number 9 Gilpin Road		10	f. Zip Code 19	090		_	en of What Cou United	,
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel" or items 23e or 28e-f show eny injury or other treumetic event, its Medical Evant exclusive multibul unonce.	by Funeral	1 Never Married 2 Married 1	Vas Decedent Ever in U.S. rmed Forces?  ☐ Yes 2★ No Yes, Give ear or Dates:		Decedent of His specify Cubar es 2 KNo	spanic Origin , Mexican, P Specify:	? (Specify Yes or No- uerto Rican, etc.)		4. Race - Ameri Black, White, Specify:	
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Maryland 2	uld be filed fental Hyg rked othe tic event,	To Be C	17. Father's Name (First, Middle, Last)  George W. Purvis				18. Mother's	Name (First, Middle, Anna Han		umame)	SCHOOL
, Mary	and 2 shorell and N 27 Is ma		19a. Informant's Name/Relationship (Type, P Robin Dowell / Daught					r Rural Route Numbe			
Baltimore,	Pages 1 and of He nent of He nert: If item		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☑Remov 4 ☐ Ponation 5 ☐ Other (Specify)	rai ii Oili State	crematory	(Name of or other place remator		Date 25/2005		ation - City or To adelphi	
Balt	permit. Departr Importe eny inj		21. rignatur of Funeral Service Licensee	Sinden	22. Nan	e and Address Wilke:	of Facility		Fune	ral Ho	ome, Inc.
	Cate be executed // Medical Examiner the private and the private that the	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	Due to (or as a consequence of):  Due to (or as a consequence of):	6			diac or respiratory and	est,		Approximate Interval Between Onset and Death
Box 6	death certifi e attending id tor use as	Physician/Medi	in the past 12 months?	yes, outcome of pregnancy □Live birth 2 □Fetal death □Pregnant at time of death □Unknown		ic pregnancy r (specify)			230	d. Date of delive Month	ery Day Year
Records, P	The law requires that the the law been signed by the bage 2 should be detached.	þ	Part II. Other significent conditions contributed on the significant conditions contributed to the significant conditions contributed to the significant conditions contributed to the significant conditions contributed to the significant conditions contributed to the significant conditions contributed to the significant conditions contributed to the significant conditions contributed to the significant conditions contributed to the significant conditions contributed to the significant conditions contributed to the significant conditions contributed to the significant conditions contributed to the significant conditions contributed to the significant conditions contributed to the significant conditions contributed to the significant conditions contributed to the significant conditions contributed to the significant conditions contributed to the significant conditions co	ing to death but not resulting in th	e underly	ng cause given	in Part I.	23e. Did tol		4	ne cause of death?
		e Completed	25. Was case referred to medical						y ned?, 2 No	prior to cor death?	psy findings available πpletion of cause of 2□ No
ō	Phy rald	ToB	examiner?  1  Yes 2 No Hospits  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	al: 1   Inpatient 2   ER/Outpa a. Date of Injury (Month, Day Year)   28b. Tim Injur	e of	DOA Other: 28c. Injury a Work?	4 🗆 Nursin	Death (Check only on g Home 5 ☐ Reside 28d. Describe ho	nce 6'5	Other (Specify	daughters
S S	Hospitel or Attending 24 hours after death. Funerel Director: After tely tilled in by the fune	l Certification;	4   Homicide	s. Place of Injury - At home, farm, building, etc. (Specify)				28f. Location (St. City or Town	, State)		
;	I o the Hospitel within 24 hours at To the Funerel D completely tilled i	Medical	one) 2 medical Exeminer: 0	To the best of my knowledge, de in the basis of examination and/or and manner stated.	eath occur r investiga	tion, in my opin	ion, death or	ccurred at the time, da	ate and pla	ace, and due to	the cause(s)
	TC	-	29b. Signature and title of certifier	0		29c. License r	a54	29		igned (Month, L	Day, Year)
	25		30. Name and address of person who complete	2 900 Cator	pe, Print)	e BA	LTIM	ione M	02	1220	2
	Stat Registra	e ir	31. Date filed (Manth Pay, Year) 2005	3. Registrar's Signature	med						

			1 - For State Registrar	State of	of Maryla		artment o			Mental Hy	/giene	05	13870
			1. Decedent's Name (First, Midd	le, Last)					-	2. Date of De			3. Time of Death
	Physici		Margaret G	Nomick						Month April	Day	Year 2005	5:458 M
	/Medic Examir		4a. Facility Name (If not institution		ımber)		4b. City, Tow	T or Locate	ion of Death	APILI		tv of Death	2,751
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			5. Social Security Number	6. Sex		: y s. last birthday)	If Under 1 Y	imore	der 24 Hrs.	8. Date of Bi	rth	Balti	
Н	Funeral Director		216-28-4919	1 M 2 1 F			Months Da			(Month, Da	av. Year)		olece (State or Foreign ntry)
			Usual Residence of Decedent		7	<u>Z</u>				July 3	30,1932	Mary	land
	land		10a. State 10b. County	,	10c. C	ity, Town or Lo	ocation					1	Od. Inside City Limits
	Many f sh	ō	M 1 1 1	1									1 ☐ Yes 2 🖾 No
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	with a or	ã		O							10g. Citizen of		ntry?
	filed within 72 hours after death with the Maryland Hygiene. kther then "natural", or Items 23a or 28a-f show ont, the Medical Exameter intel to mullified at	Funeral	2115 Ganton			1.0		1163			U.S.		
	er de Item	Ľ,	11. Marital Status	Armed Fo		U.S. 13.	Was Decedent If Yes, specify (	of Hispanic Cuban, Mex	: Origin? (Sp tican, Puerto	ecify Yes or No Rican, etc.)		ce - Americack, White,	
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ב	9 ~ 5 P	Be		,				18. M			, Maiden Suma	-	
Maryland	ages I and 2 should be filed withir nt of Health and Mental Hygiene. : If item 27 Is marked other then or other traumatic event, I'm M.	L <sub>o</sub>	Thomas E. Perry								th Mage		
ā	2 sh and Is m		19a. Informant's Name/Relations		_						er, City or Town		
	1 and Health em 27		Kimberly A. Cra	ampton (Da							le, Mar	yland	21784
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altimore,	permit. Pages Department of I Important: If its any injury or of		21. Signature of Funeral Service	Licenses /	1)	22	. Name and Ad	dress of Fa	acility				
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			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that	caused the dea	ith. Do not ent	er the mode of	dying, such	as cardiac	or respiratory a	rrest,	PIL)	Approximate
	Pnysician		Immediate Cause (Final	only one cause on a	each ime.	-20 - 10 - AL	. / (	•					Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a. Hy	(or as a conse	and the state of t	mia/	repsi	<u>د</u>				nonths
	Examiner			M	. I h	ا أ المام						1.	И
		ē	Sequentially list conditions, if any leading to immediate	b. Due to	(or as a planse	quence off:						V	renths
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o.	the a	Physiclan/M	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4∐Pregr 9☐Unkn	nant at time of o	death 5∟	Other (specify						Day ( Cal
Ţ.	w requires that the death certif been signed by the attending should be detached for use a	P	Part II. Other significant condition	one contributing to d	anth hut not cou					00. 0:4.			
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5	nedni sen s	ted	_ cerebra /	4 12 (2) 7	WITH	rese	CLICH			1 1 1	Yes 2be2No ———	3∐ Proba	ably 4 Unknown
ပ်	as b	ompleted	Anem. q							24a. Was autop	an 24b.	Were autop	osy findings available apletion of cause of
vital Records,	ilclen: The lav certificate has rector, page 2	OT								perfo	rmed?	death?	
	Physiclen: this certificated director,	BeC	25. Was case referred to medical					26. Pl	ace of Death	(Check only o		103	2 140
	Physiclen: this certific al director,	0	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 □ I	Inpatient 2	] ER/Outpatien	3 □ DOA	2.1			dence 6 Oth	er (Specify	)
0	ding Ph h. After th funeral	Liu	27. Manner of Death	28a. Date	of Injury th, Day Year)	28b. Time of	28c. lr	jury at Vork?			now injury occur		/
<u></u>	ndin ath. r: Aft	읉	1 ☑Natural 5 ☐ Pendin 2 ☐ Accident investig		in, Day 16ai)	Injury		vonc? ∐Yes 2	□No				
UNISION	Atte	ertification;	3 Suicide 6 Could a	inod 286, Place	of Injury - At h	ome, farm, stre	et, factory, offic	ю	× 1	28f. Location (S	Street and Numb	er or Rural	Route Number,
5	el or efte 1 Dir d in l	ert	4   Homicide	buildi	ng, etc. (Speci	Ty)				City or Tou	vn, State)		
	hours mere / fille	aC	29a. Certifier 1 ☐ Certifyin	g Physician: To the	best of my kno	owledge, death	occurred at the	time, date	and place.	and due to the	cause(s) and ma	anner as sta	ated.
	To the Hospitel or Attending Physipin 24 hours etter death. To the Funerel Director: After th completely filled in by the funeral	edical	(Check only 2 Medical one)	Examiner: On the ba	asis of examina ner stated.	ation and/or inv	estigation, in m	y opinion, o	death occurr	ed at the time,	date and place,	and due to	the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifie				29c. Lice	nse numbe	er		29d. Date signe	d (Month, E	Day, Year)
	/.		> /hh	0 H -			17	2 2 2	AC ?		. /	1	
•	1		20 Name and address of	who completed	o of death the	- 02e) CT		333	20		711.	3/0	5
١	U		30. Name and address of person			7 / A	7 (nt)	- (	1	0	0 1	1	4.5
	Stat	ċ	31. Date filed (Month, Day, Year)		いし、 <b>グ</b> istrar's Signa	ature	MAZINE	م) رد	e hite	V 421,	reiste	atom	עדון א
	Registra		APR 2		Programs	13 13	Carles .				4/2. Reiste		

			nd item#19b,perIni Please amend item#19 1- State Registrar	Type or Pri b, perFH, G8 State of M	nt in Blac 42,4725 aryland / I	<b>Indelible In</b> Department of Certificate o	k. Ensure A Health and	<b>All Copie</b> Mental H	s Are Legi ygiene	ble.
			Negistrar     Necedent's Name (First, Middle, Lager Lag			Certificate 0	Dealii	2. Date of D	Reg. No. 🛴 🔱	3. Time of Death
	Physic /Med		MICHAEL ALFON	ZA PULLE	N:			April	Day	Year 7:30 AM
-	Exami		4a. Facility Name (If not institution, gire			4b. City, Town	, or Location of Deat	h	4c. County	of Death
	Funeral	•	5. Social Security Number 6.	Healthco	je (In yrs. last bir	thday) If Under 1 Yea	ar If Under 24 Hrs	8. Date of B	N N	_1_
	Director		641C.00.214	<b>⊠</b> M 2□F	52	Yrs. Months Day	s Hours Min.	8. Date of B (Month, D 05 · 31	Pay, Year) 1952	Birthplace (State or Foreign Country)     MD
	viand ow		Usual Residence of Decedent  10a. State  10b. County		10c. City, Tow	n or Location			, , , , ,	10d. Inside City Limits
	e Man Sa-1 sh	ctor	MD BALT	MORE	GWYN	N OAK				1 ☐ Yes 2 KNo
	ours after death with the Maryian rai', or Items 23a or 28a-1 show Evaminer must be rodiffed at	Funeral Director	10e. Street and Number	י מאמע אי	1	10f. Zip Code			10g. Citizen of W	
	death ms 23	era	5505 W. FOREST	12. Was Decedent		13 Was Decedent of		pacity Vac or N	US/	e - American Indian.
98	or ite	y Fur	1 Never Married 2 Married	Armed Forces?  1 Tyes 2 Kill If Yes, Give		13. Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 🖔 N		to Rican, etc.)		k, White, etc.
Ö	72 hours aff	ed by	3 ☐ Widowed 4 🗷 Divorced	Year or Dates:	1.40-					BLACK
215	hin 72 an na	Completed	(Specify only highest gn			Decedent's Usual Occ (Give kind of work don life. DO NOT use retir	e during most of wor	rking	16b. Kind of Bu	siness/Industry
2	be filed within 72 h ital Hygiene. id other than "natu event, tre Medical		12 TH GRADE	NA	CA	RPENTER				REALTOR
lanc	ould be filed within 72 hours after death with the Maryland Mental Hygiene. arked other than "natural", or items 23a or 28a-f show latic event, the McAlful Evantinat must be rotified at	To Be	17. Father's Name (First, Middle, Last NATHANIEL PULL				18. Mother's Nan REBECC		e, Maiden Sumame OMAN	э)
Maryland 21215-0036	s 1 and 2 should be filed withir F Health and Mental Hygiene. Item 27 Is marked other than other traumatic event, Le Ma	-	19a. Informant's Name/Relationship (		19b.	Mailing Address (Stree	at and Number or Pu	ral Bauta Numi	91	ate, Zip Code)
	1 and 2 Health em 27 I		GLADYS PULLEN	····	515	BALLO MAI	C PIKE	Baltimon	e, MD 2122	N Augusta Avenue
nore	ages 1 nt of F t: If ite		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from State	cemeter	Disposition (Name of y, crematory or other pl	ace)	Date	20c. Location - (	City or Town, State
Baltimore,	permit. Pages 1 and Department of Health Important: If item 27 Ray injury or other tr		<ul><li>4 □ Donation 5 □ Other (Specif</li><li>21. Signature of Funeral Service Licer</li></ul>		ARBUM				BALTO.	
ä	Deg Pring	35 1	) Vangk (	1		VAUGHN C. 5151 BALTO	NATT: PIKI	E. BAIT	7. MD 2	3 11229
			23a. Part1. Enter the disease, or comshock, or heart failure. List only	one cause on each in	10.	ot enter the mode of dy	ring, such as cardiac	or respiratory a	arrest,	Approximate Interval Between
	Pnysician /Medical	6 1	Immediate Cause (Final disease or condition resulting in death)	a. MACIO	ENAN!	PLEUR 10: CEEAR	AL EF	FUSI	000	Onset and Death
	Examiner		Conversion to the same distance	Due to (or as:	a consequence of	CEAL	CHAIC	= 1		Tac YEAN
	be sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	я сольециелсе с	():	11100			, 55 7 7 6 7 70
,	executed n and al-transit	Examin	that initiated events resulting in death) Last	c. Due to (or as a	a consequence o	f):				
68760	icate be ex physician s the buria			d						
x 68	the death certificate be executery the attending physician and Iched for use as the burial-trans	by Physician/Medical	IF FEMALE:	00 11						
Box	death c	clan	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal death	3 □Ectopic pregnand 5 □ Other (specify)	<b>Э</b>		23d. Date Mont	of delivery h Day Year
P.O.	that the de ed by the detached	hysl	1 Yes 2 No 9 Unknown	9□ Unknown						,
	Se OD O	by F	Part II. Other significant conditions o	entributing to death bu	it not resulting in	the underlying cause gr	ven in Part I.			oute to the cause of death?
Records,	> 9 %	eted	1) ( R IS	61 67					Yes 2□No 3	Probably 4 Unknown
Rec	e la has je 2	Completed						24a. Was autor	osy pri	ere autopsy findings available or to completion of cause of ath?
Vital	ician: Th certificate ector, pag	BeC	25. Was case referred to medical				26. Place of Deat		2 🗙 No 1 🗆	Yes 2□No
of V	iding Physician: th. After this certifica funeral director, p	၉	examiner?	Hospital: 1 Inpatier		Attent SU DOA	her: 4 Nursing Ho		dence 6 ☐Other	(Specify)
on	Attending Ir death. sctor: After	tlon	27. Manner of Death  1 ★ Natural 5 Pending 2 Accident investigation	28a. Date of Injun (Month, Day	Year) 28b. Ti	ury Wo	ryat rk? ]Yes 2 □ No	28d. Describe I	how injury occurred	
Division of	r Attendi er death. rector: A by the fu	Certification:	3 Suicide 6 Could not be determined	28e. Place of Inju	ry - At home, farr	n, street, factory, office		28f. Location (S	Street and Number	or Rural Route Number,
Ö	oital or urs after ral Dis			1				City or I ov	vn, State)	
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical	29a. Certifier  (Check only one)   Certifying Phy  2 ☐ Medicel Exem	sician: To the best of iner: On the basis of and manner state		death occurred at the ti or investigation, in my	me, date and place, opinion, death occuri	and due to the red at the time,	cause(s) and mann date and place, an	ner as stated. d due to the cause(s)
	To the within To the Complete	Me	29b. Signature and this of certifier		-	29c. Licens			29d. Date signed (	
-	1		1 Spel	M	aus	000	61765	-	APMIL	20 2005
ム	1		30. Name and address of person who de	ompleted cause of de	ath (Item 23a) (T	ype, Print) UIUCONS				
7	Sta		31. Date filed (Month, Day, Year)	32 Registra	's Signature	South	100 131	MC (M	one m	1) 21229
	Registr	ar	APR 2 5 21	105 Deglar	15.	GOBALL				

			1 - State Registrar Co	partment of Health and Mertificate of Death	Reg. No	21105 10076							
	Physici	an	1. Decedent's Name (First, Middle, Last) William Edgar Dhilling		2. Date of Death April Da								
	/Medi	cal	William Edgar Phillips	Ab Co T									
	Examir	ier	4a. Facility Name (If not institution, give street and number)  6 Kenwood Avenue	4b. City, Town, or Location of Death Catonsville	40	. County of Death Baltimore							
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	) If Under 1 Year If Under 24 Hrs.	8. Date of Birth								
п	Director		217-12-6760 1™ 2□F 78 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Year) Sept 21, 1	Year)  9. Birthplace (State or Foreign Country)  1, 1926 Maryland							
	pu ,		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or										
	faryla shor	ō	Maryland Baltimore Catonsvi			10d. Inside City Limits 1 ☐ Yes 2 No							
	ith the Marylar or 28e-f show	ect	10e. Street and Number	10f. Zip Code	10a Cit	izen of What Country?							
	3a or	<b>Funeral Director</b>	6 Kenwood Avenue	21228	_	uited States							
	death ms 2	nera		. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto F		14. Race - American Indian,							
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. item 27 is marked other than "natural", or Items 23a or 28e-f show other traumetic event, the Medical Evantarial contributed at	by	1 Never Married 2 Married 1 Yes, Give 3 Widowed 4 Divorced Year or Dates:	If Yes, specify Cuban, Mexican, Puerto F  1 ☐ Yes 2 ☑ No Specify:	Rican, etc.)	Black, White, etc.  Specify: White							
5-0	72 ho natur	Completed	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Giv	edent's Usual Occupation	16b. K	ind of Business/Industry							
121	vithin ne. han "	mple	Elementary/Secondary (U-12) College (1-4or 5+)	e kind of work done during most of workir DO NOT use retired)		and electric co.							
2	filed within Hygiene. Ither than "		11 0 in	spector	(First, Middle, Maiden								
an	d be antal cad o	To Be	Charles Phillips	Sarah Qui		Surrame)							
ary	2 should be and Mental is markad c	F		ling Address (Street and Number or Rural	<del> </del>	r Town, State, Zip Code)							
	and 2 lealth a m 27 is			nwood Avenue, Balti									
Baltimore,	0 0		20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State 1 Donation 5 Other (Specify)  20b. Place of Dispository, cr	position (Name of paratory or other place) edral Cemetery 4/28		ocation - City or Town, State							
Balti	permit. Pag Department Importent: I any injury o once.				al Home, Inc. , Maryland 21229								
			23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.			Approximate Interval Between							
	Physician <sup>1</sup>		Immediate Cause (Final disease or condition	en als se	1 0	Onset and Death							
	/Medical Examiner		Due to (or as a consequence of):										
	LAGITITICS	_	Sequentially list conditions, b. a Hy	no selentic a	rslave	( 2975							
	ted nsit	nine	Sequentially list conditions, if any, leading to infimediate cause. Enter Underlying Cause (Disease or injury										
	be executed sician and burial-transit	Examiner	that initiated events resulting in death) Last C.  Due to (or as a consequence of):										
8760,	e be (sicial)	dical I	d										
9	tificate t ig physia as the b	edi											
O. Box	that the death certificate be executed ed by the attending physician and detached for use as the buriat-transit	Physiclan/Med		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year							
S, P	requires that the een signed by th hould be detache	by Ph	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco u	se contribute to the cause of death?							
rds	quires in signi uld be				1 🗆 Yes 2 [	No 3 Probably 4 □Unknown							
of Vital Record	> 0 0	Completed			24a. Was an	24b. Were autopsy findings available							
æ	9 2 9	ШО			autopsy performed?	prior to completion of cause of death?  1 ☐ Yes 2 ☐ No							
<u>ta</u>	sician: Th certificate rector, pag	Bec	25. Was case referred to medical examiner?	26. Place of Death	4	10103 2010							
of V	dis di	٥	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie		e 5 Residence	S ☐ Other (Specify)							
u c	ding Ph h. After th funeral	on:	27. Manner of Death  1 Natural 5 Pending (Month, Day Year)  28b. Time (Month, Day Year)	Work?	8d. Describe how injury	y occurred							
Sic	tan Jeat tor: the	cat	2 Accident investigation	M 1 Yes 2 No	01.1								
Division	i Pite	Certification:	4 Homicide determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	геет, тастогу, опісе	City or Town, State,	d Number or Rural Route Number,							
	유 구 교 수	edical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, deal carminer: On the basis of examination and/or in and manner stated.	h occurred at the time, date and place, ar evestigation, in my opinion, death occurre	nd due to the cause(s) d at the time, date and	and manner as stated. place, and due to the cause(s)							
)	To the within 2 To tha complet	Σ	29b. Signature and title of certifier	29c. License number  2 9 7		e siggred (Month, Day, Year)							
	8+1		30. me and advess of person who completed cause of de th (Item 3a) (Type	1 5/60. Roll	(in bel	Bu (1 278							
	Sta	- 34	31. Date filed (Month, Day, Year) 32. Digistrar's Signature	O		1							
	Registr	ar	MPH 2 5 2005 States A. A.	gares/									
DHI	MH 17 Rev 1/20	01											

ORIGINAL

			1 State	artment of Health and Mental rtificate of Death	4000 13873
			Registrar  1. Decedent's Name (First, Middle, Last)		Reg. No. of Death 3. Time of Death
	Physici		EMMA C PATR	ICK Mont	Day Year 20 2005 8:00 A M
	/Medic Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
			3042 WINDSOR AVENUE	BALTIMORE	NIA
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	If Under 1 Year   If Under 24 Hrs.   8. Date   Months   Days   Hours   Min.   (Months   Months   Mon	th. Day Year) Country)
	Director		Usual Residence of Decedent	9	27 1938 MD
	/land		10a. State 10b. County 10c. City, Town or L	ocation	10d. Inside City Limits
	the Marylan 28a-f show	tor	MD NA BALTIMORY	É	1 X Yes 2 □ No
	or 284	Director	10e, Street and Number	10f. Zip Code	10g. Citizen of What Country?
	23a	rai	3042 WINDSOR AVENUE	21216	USA
	ltems ner nu	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (Specify Yes If Yes, specify Cuban, Mexican, Puerto Rican, etc.	or No- 14. Race - American Indian, c.) Black, White, etc.
36	hours after deeth with the Maryland tural', or Items 23a or 28a-1 show al Examiner must be notified at	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 15 No If Yes, Give 3 ☐ Widowed 4 15 Divorced Year or Dates:	1 ☐ Yes 2 M No Specify:	Specify: BLACK
21215-0036	"natural",	ed	15. Decedent's Education 16a. Dece	dent's Usual Occupation	16b. Kind of Business/Industry
215	within 72 ene. than "nat	pie	Flementary/Secondary (0-12) College (1-4or 5+) life.	kind of work done during most of working DO NOT use retired)	- 1
21	filed with Hygiene Ather thai	Completed	II TH GRADE NA HOUSE	E KEEPER	FOREST HAVEN N.H.
nd	be file tal Hy doth	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, M	
Maryland	s 1 and 2 should be filed within 72 hours after death with the Maryla I Health and Mental Hygiene. Item 27 Is marked other than "natural", or Items 23a or 28a-1 show ther traumatic event, the Medical Examiner must be multified at	2	JOHN SPRIGGS	MILDRED BA	
Ma	d 2 st th and 7 Is n traun		19a. Informant's Name/Relationship (Type, Print)  ROCHELLE MAYNE  1513	ng Address (Street and Number or Rural Route N WEYBURN RD., BAUTO	0.000
	of Health Item 27 other tra		20a. Method of Disposition 20b. Place of Disp	osition (Name of Date	20c. Location - City or Town, State
OLL	Pages nent of int: If it		1 👺 Burial 2 □ Cremation 3 □ Removal from State  1 □ Cremation 3 □ Removal from State  1 □ Cremation 3 □ Removal from State  1 □ Cremation 3 □ Removal from State	matory or other place)	RANDALISTOWN MD
altimore,	- 본본공				
ä	Depar Depar Impo		Vanch Com	RUAMP and Address of Facility Funer 151 BAUD: NATO PIKE, BI	AUD- MU 21229
			23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or hear failure. List only one cause on each line.		
	Physician		Immediate Cause (Final disease or condition	Cartie Failures	Onset and Death
	/Medical Examiner		resulting in death)  a. Due to (or as a consequence of):	D 1 1:	a wise
		-	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):	, heart disease	620113
	ted	nine	cause. Enter Underlying Cause (Disease or injury		(Jests)
	s be executed sician and burial-transit	Examiner	that initiated events c		
8760,	cate be executed physician and the burial-transit	dicai			
9	rtificate ng phys as the	a o	IF FELLING		
Вох	leath certific attending p	an/h	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3	Ectopic pregnancy	23d. Date of delivery
	the at	Physician/M		Other (specify)	Month Day Year
P.0	The law requires that the death certifi tte has been signed by the attending i age 2 should be detached for use as		Part II. Other significant conditions contributing to death but not resulting in the t	anderhying cause given in Part I 23e	Did tobacco use contribute to the cause of death?
ds,	signe d be	d by	Coronary astery	20	1 ☐ Yes 2 1 No 3 ☐ Probably 4 ☐ Unknown
Sor	w requir	lete	Alcoholism	249	Was an 24b. Were autopsy findings available
Records,	The lav	Completed	711070011 3171		autopsy prior to completion of cause of death?
Vital		a	25. Was case referred to-medical	1 ☐ Y	
Ž	d is	To B	examiner?  1  Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpatie	Other	Residence 6 □Other (Specify)
n of			27. Manner of Death 1 ☑ Natural 5 ☐ Pending 28a. Date of Injury (Month, Day Year) 1 ☐ Pending 28b. Time of Injury	f 28c. Injury at 28d. Desc Work?	cribe how injury occurred
Sio	death, ctor: A the fu	catle	2 Accident investigation	M 1 Yes 2 No	
Division	I or Attendate after death Director:	Certification:	4 ☐ Homicide determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office 28f. Locat	tion (Street and Number or Rural Route Number, or Town, State)
	pital purs a eral I		29a. Certifier 1 Certifying Physician: To the best of my knowledge, deat		1
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	edical	(Check only one)    Check only one)	vestigation, in my opinion, death occurred at the t	time, date and place, and due to the cause(s)
	To the within To the Somple	Me	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	1.		In . U. Sul MD		4-21-05
2	0		30. Name and address of person who completed cause of death (Item 23a) (Type,	Print)	
			JAVAID M SHAFI MD, 230	o garlisor Blue Bi	ALTINORE MD21216
	Sta Registr		31. Date filed (Month, Day, Year) 2005 Registrar's Significate APR 2 5 2005	Print) Garlisod Blud B,	

		For State Registrar	State of Marylan	d / Depa			lental Hy		005	13871
		Decedent's Name (First, Middle, Language)	ist)				2. Date of De	ath		3. Time of Death
Physicia /Medic Examine	al	GENEVIEV  4a. Facility Name (If not institution, gi	E ELIZA	BETH		TER or Location of Death	Month April	20, 20	Year 005 nty of Death	10:04A M
Examine	er	Greater Baltimo		tor		owson			imore	
Funeral Director		5. Social Security Number 6. 2/7-40-//99	Sex 7. Age (In yrs.			If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th ly, Year)		place (State or Foreign http) RYLAND
and *		Usual Residence of Decedent  10a. State 10b. County	10c. Cit	y, Town or Lo	ocation					0d. Inside City Limits
PVP. 1215-0036 within 72 hours after death with the Maryland ane. than "natural", or items 23s or 28e-f show than "natural", or items 23s or 28e-f show in Madical Exercites chast be recilified at	Completed by Funeral Director	MARYLAND A	IIA		BAL	TIMOR	E CI	TY		1 XYes 2 No
with th		10e. Street and Number			10f. Zip Code	21210	7	10g. Citizen o	of What Cour	ntry?
s 23s	sral	1531 NOR	1	5/1	Was Davidson - (1)	$\alpha/\alpha/\gamma$	/	14.0	451	7
ter de Item	Ľ.	11. Marital Status  1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☒ No	.5. 13.	If Yes, specify Cub	Hispanic Origin? (Spe an, Mexican, Puerto	Rican, etc.)	)- 14. H	ace - Americ lack, White,	
5-0036 72 hours all natural; or	þ	3   Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1⊡Yes 2KQNo	Specify:		Spec	city: 131	ACK
5-0 72 ho	eted	15. Decedent's E (Specify only highest gi	ducation	16a. Dece	dent's Usual Occup	pation during most of worki	na	16b. Kind of	Business/Inc	dustry
Parin Jahrin 197	d d	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	1	during most of worki	9			- 44
O nat	ပိ	17. Father's Name (First, Middle, Las	£1		DIETI	18. Mother's Name	/Eimt Middle		EOF	MARYLAND
g E B E S	Be	A	BI	100	WELL	Mother's Name	(First, Middle,	_	ame) ORG	, ,
laryla laryla should and Men is marke	၉	DAVID  19a. Informant's Name/Relationship	(Type, Print)			and Number or Flura	I Route Number			
(6+4), Maand 2 s ealth ar n 27 is		JEANETTE ROP	INSON DAUGHTER	44:	200084	DAMAK A	LVE VA	ALTO.		21212
rre, M s 1 and 3 f Health item 27 other tr		20a. Method of Disposition	20b. P	lace of Dispo	sition (Name of matory or other place		ate	20c. Location		
Pages nent of lury or o		Burial 2 ☐ Cremation 3 [  4 ☐ Donation 5 ☐ Other (Special Control of Control	Hemoval from State			RK 4-2	5-05	unal	LAWN	IMD.
Baltim Baltim Permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Lice			2. Name and Addre		OUN	TR. Fu	NERA	L HOME 10 21217
Q5	- 62	23a. Part1. Enter the disease, or con	aplications that caused the deeth	n. Do not ent	er the mode of dyir	ng, such as cardiac of	or respiratory a		210.19	Approximate
Physician		shock, or heart failure. List only Immediate Cause (Final disease or condition	a. Lum	a Ca	incine	ma			T	Interval Between Onset and Death
/Medical Examiner		resulting in death)	Due to (or as a conseq	ence of):						
n =	ner	Sequentially list conditions, if any, reading to infine unate cause. Enter Underlying Cause (Disease or injury	b. Zue to (or as a consequ	uentee ut):						
60, be executed ician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a consequ	ience of):						
	calE		. d.	301100 017.						
68' tiflicat as th										-
P.O. Box 68' nat the death certificat d by the attending phy letached for use as th	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de	death 3	Ectopic pregnancy Other (specify)	y		1	Date of delive	ery Day Year
the d	hys	1 □ Yes 2 ØNo 9 □ Unknown	9□ Unknown							
S, P.O. Bo	by Pi	Part II. Other significant conditions	contributing to death but not resi	ulting in the u	nderlying cause grv	ren in Part I.	-			e cause of death?
Cord * requir	ted						120	Yes 2□No	3   Prob	ably 4 ☐Unknown
Division of Vital Records, or Attanding Physician: The law requires thater death. Director: After this certificate has been signed in by the funeral director, page 2 should be or	Completed						24a. Was autop		prior to cor death?	psy findings available npletion of cause of
al F			r <del></del>				1 ☐ Yes	2 <b>X</b> No	1 Yes	2 No
Vit siciar certifirecto	Be	25. Was case referred to medical examiner?	Hospital:		Oth	26. Place of Death				
on of Vita	To	1 Yes 25 No 27. Manner of Death	28a. Date of Injury	ER/Outpatier 28b. Time of	28c. Injur	y at 2	ne 5∟Resid 28d. Describe i			/)
ion nding th. : Afte e func	텵	1 Natural 5 ☐ Pending investigation	(Month, Day Year)	Injury	Wor M 1□	rk? Yes 2∐No				
ViSi Attau er dea ector by the	) E	3 ☐ Suicide 6 ☐ Could not to determined		me, farm, str	eet, factory, office	2	28f. Location (\$ City or Tox	Street and Nun	nber or Rura	l Route Number,
Di itel or ris after rel Dir	Certification;	Tomore	building, etc. (opecn)			1		vii, State)		
Division of Vital Records, P.O. Box 68 To the Hospitel or Attanding Physician: The law requires that the death certifica within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending ph completely filled in by the funeral director, page 2 should be detached for use as the	Medical	29a. Certifier (Check only one) 1 Certifying P 2 Medical Exa	hysician: To the best of my kno miner: On the basis of examinal and manner stated.	wledge, deatl tion and/or in	n occurred at the tir vestigation, in my o	me, date and place, a pinion, death occurre	and due to the ed at the time,	cause(s) and r date and place	manner as st e, and due to	ated. the cause(s)
To th within To th comp	Ž	29b. Signature and title of certifier	A- Your	MI	29c. Licens	se number		29d. Date sign	ned (Month, I	2 (20) \$
		30. Name and address of person who	completed cause of death (Item	23a) (Type,			rome, M	Parkey	1 >	2 100
W		31. Date filed (Month, Day, Year)	32. Registrar's Signa	DIVITUI (	war 140	Pacri	voice;	ary lun	R -1	-07
Stat Registra			M	Lo 4	Carte					
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ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 2 1 1 5 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 1820 George Edward Pindell April 18 2005 /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Union Memorial Hospital Baltimore 8. Date of Birth (Month, Day, Year)
Dec. 21,1931 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral**  Birthplece (State or Foreign Country) Days Months Hours 1**X** M 2 □ F Yrs. Director 219-28-0058 73 Maryland Usual Residence of Decedent the Maryland 10a, State 10c. City, Town or Location 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Heelth and Mental Hygiene. Importent: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other treumatic event, the Medical Examinat must be notified at 1KYes 2 No Director Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1616 Sexton Street 21230 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ☐Yes 2 🔀 No Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Š Specify: If Yes, Give Year or Dates: 3 X Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Commercial Credit Chief\_Purchasing\_Agent 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joshua Ellsworth Pindell Delia Charlotte Ripley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Pindell (Son) 11555 Monument Lakes Circle Jacksonville, FL 32225 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Loudon Park Cemetery 4-22-2005 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Ave. Catonsville, Maryland 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Artem Physician Coronani Disease NIA /Medical Due to (or as a consequence of): Examiner Mitral 20 days and tricuspid Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Qualto for as a nonsequanna off-Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Box 68760 Physician/Medical es the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 🔀 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 🗌 Yes 1 Yes 2 No 2 No or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🕱 No 2 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification 1 Natural 5 Pending investigation s after death. 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 \ Homicide To the Hospitel o within 24 hours aft To the Funeral Di 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical Surgical Resident 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 4/ 18/05 AT 2438946 -E19 Mchammada

Registrar DHMH 17 Rev 1/2001

State

REZA

31. Date filed (Month, Day, Year)

Sparke

Union Memorial

32. Registrar's Signatule

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2005

MOHAMMAN

Registrar
DHMH 17 Rev 1/2001

State

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gistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RNBID

APR 2 5 2005

31. Date filed (Month,

OCME

111 Penn Street

April 17, 2005

Baltimore, Maryland 21201

			4 10	eartment of Health and Mer	ntal Hygie	- CUUD 138/1
	Physici	an	Decedent's Name (First, Middle, Last)		Date of Death Month	Day Year 3. Time of Death
	Physici /Medic		KENNETH CHARLES PATTERSON, JR.	A	APRIL	21, 2005 8:10 A.M
	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
	F		1000 PLEASANT OAKS ROAD APT. B 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	PARKVILLE ) If Under 1 Year   If Under 24 Hrs.   g.	Date of Birth	BALTIMORE
	Funeral Director		086-32-1675 1⊠M 2□F 63 Yrs.		(Month, Day, Ye) 18/194	9. Birthplace (State or Foreign Country) NEW YORK
	pu 🔏 🐷		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or L			
	Aaryla f sho	ō				10d. Inside City Limits 1 Tyes 2 XNo
	28a-	rect	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Country?
	h with	ai Di	1000 PLEASANT OAKS ROAD APT. B	21234		USA
	ems (	Iner	11. Marital Status 12. Was Decedent Ever in U.S. 13. Agmed Forces?	Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Rica	y Yes or No-	14. Race - American Indian, Black, White, etc.
36	within 72 hours after death with the Maryland one. Then "naturel", or Items 23s or 28s-f show he died Evaniner must be notitied at	by Funeral Director	1 ☐ Never Married 2 ⚠ Married 1 ☒ Yes 2 ☐ No If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates: VTFTNΔM	1 ☐ Yes 2X No Specify:	,	Specify: WHITE
21215-0036	ture			edent's Usual Occupation	16h	. Kind of Business/Industry
215	hin 72 a. an "ne	piet	(Specify only highest grade completed) (Giv.  Elementary/Secondary (0-12) College (1-4or 5+)	e kind of work done during most of working DO NOT use retired)	, 52	. And of Business industry
N	filed wit Hygiene other the	Completed	12TH GRADE MAINT	ENANCE TECHNICIAN	A	PARTMENT RENTAL CO.
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hyglene and the file and 1884 is marked other then "naturel", or thems 28a or 28a-1 show other traumatic event. The Mudical Evantines must be notified at	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name (Fi		den Sumame)
<u> </u>	should be ind Mental s marked o umatic eve	은		HAZEL PA		hvor Tours State 7in Code)
Z	and 2 s salth an n 27 is er trau			O PLEASANT OAKS RD.	APT. B	BALTMORE, MD 21234
re,	s t and s of Health item 27 other tra		20a. Method of Disposition 20b. Place of Disposition	osition (Name of Date	20c	Location - City or Town, State
<u>i</u>	Page nent c ant: If ury or		I Dunal 2 Demation 3 Hemoval from State	EMATORY, INC. 4/22/2	005 CA	TONSVILLE, MD
Baltimore,	permit. Pages 1 an Department of Heal Important: If Item 2 any injury or other once.			2. Name and Address of Facility THE 8521 LOCH RAVEN BLVD		FUNERAL HOME, P.A. ON,MD 21286
		5 1	23a. Fart1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause of each line.	ter the mode of dying, such as cardiac or re	espiratory arrest,	Approximate Interval Between
	Physician	į į	Immediate Cause (Final disease or condition resulting in death)	rcinoma, metastatic	to brain	and Onset and Death 2 1/2 years
	/Medical Examiner		Due to (or as a consequence of):	mediashnum		
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	melliasnoum		
1	d d ansit	Examiner	cause, Enter Underlying Cause (Disease or injury that initiated events			
o,	a exectan an	Exa	resulting in death) Last Due to (or as a consequence of):			
8760,	ficate be executed physician and is the burial-transit	dicai	d			
Box 6	The law requires that the death certificate be executed the has been signed by the attending physician and bagge 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b Was decoded program: 23c. If yes, outcome of pregnancy			23d Date of delivery
a	death atter	ciar	23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No  23b. Was decedent pregnant in the past 12 months?  4 □ Pregnant at time of death 5	□Ectopic pregnancy □ Other (specify)		23d. Date of delivery  Month Day Year
P.O.	that the death led by the atter detached for u	hysi	9 Unknown			
S, F	ires tha signed I be det		Part 1. Other significant conditions contributing to death but not resulting in the f	underlying cause given in Part I.		co use contribute to the cause of death?
ord	w require been si should b	ted	Chronic Obstructive Pulmonory Disease	,	1 PYes	2 No 3 Probably 4 Unknown
3ec	e taw has b je 2 st	Completed by	Non-small cell lung cancer		24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
a E	sicien: The certificate rector, pag				performed 1☐ Yes 2 <b>V</b>	
Ξ.	Attending Physicien: r death. ector: After this certifice by the funeral director, p	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie	26. Place of Death (Cl other: 4 ☐ Nursing Home	-	6 □Other (Specify)
1 0	g Phys er this eral dir	$\vdash$		The state of the s	. Describe how in	
ior	ttendin death. ctor: Aft y the fun	atio	1  Actident	M 1 Yes 2 No		
Division of Vital Records,	I or Attending after death. Director: After I in by the funer	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office 28f.	Location (Street City or Town, St	and Number or Rural Route Number, ate)
	pitel		29a. Certifier 1 Certifying Physician: To the best of my knowledge, dea	th conversed at the time, date and place and	due to the aguer	Nal and managed to the
	To the Hospitel or Attending Physicien: The within 24 hours after death.  To the Funerel Director: After this certificate h completely filled in by the funeral director, page	Medical	(Check only one)  2 Medical Examiner: On the basis of examination and/or in and manner stated.	recoursed at the time, date and place, and investigation, in my opinion, death occurred a	at the time, date a	and place, and due to the cause(s)
	To the To the Comp	Σ	29b. Signature and title of certifier	29c. License number		Date signed (Month, Day, Year)
		114	on Miller	> 1 1)42979	4	April 22,2005
	3+1	11	30. Name and address of person who completed cause of death (Item 23a) (Type	MORMD 21231	CARDUC	C1, M. D
	Sta	te	31. Date filed (Month, Day, Year) 32 Registrar's Signature	ado 1.		
	Registr	ar	30. Name and address of person who completed cause of death (Item 23a) (Type 40 No. H B Cadway Bally 131. Date filed (Month, Day, Year) 32 Registrar's Signature APR 2 5 2005			

		•	1 - State Amend Item	State of per	Maryland/Doverb.,G842	epartment of Sertificate of	Health a	nd Mental H	Hygien	2005	5   3878
	Physici	an	1. Decedent's Name (First, Middle, La					2. Date of			3. Time of Death
	/Medic	al	Marion	Pay		dh Cita Taur	and marking of		13,	2005	7:41 p M
	Examin	er	4a. Facility Name (If not institution, giver Health Co		oer)	4b. City, Town, Bowie	, or Location of	Death	40	c. County of De	eath
	Funeral		5. Social Security Number 6. S	ex 7.	Age (In yrs. last birth	day) If Under 1 Yea			Birth Day, Year	9. B	irthplace (State or Foreign
	Director		377 20 2000	□ M 2 ∏ F	90 Yr	s. Months Day	s Hours		16,19		nnsylvania
	land ow		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	or Location					10d. Inside City Limits
	Mary a-f sh	tor	Md. PG		Bowie	2					1 ☐ Yes 2 ☐ No
	ith the	Director	10e. Street and Number			10f. Zip Code			10g. C	itizen of What (	Country?
	s 23a		15598 Peach Walke		are some	20716				ISA	
980	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Healih and Mental Hyglene. If Item 27 is marked other then "natural", or Items 23a or 28a-f show or other treumatic svent, the Madical Examinat must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  X□ Widowed 4 □ Divorced	12. Was Decedor Armed Force 1 ☐ Yes 2 If Yes, Give Year or Date	es?	<ol> <li>Was Decedent of If Yes, specify Cu</li> <li>Yes 2XN</li> </ol>	ıban, Mexican,	In? (Specify Yes or Puerto Rican, etc.)	No-	Black, Wh	
2-0	72 ho natur	Completed	15. Decedent's E (Specify only highest gra		- (	ecedent's Usual Occi Give kind of work don	e durina most	of working	16b. F	Kind of Busines	s/Industry
121	within ene. then "	mple	Elementary/Secondary (0-12)	College (1-4	lor 5+)	ife. DO NOT use retii	red)	•	T-1 1	1.0	
d 2	filed Hygle Hygle Sthar I		10 17. Father's Name (First, Middle, Last,	)	Cus	stodian	18. Mother	's Name (First, Mid			overnment
lan	ould be Mental Marked o	To Be	William Bur	rell				Unknown			
Maryland 21215-0036	2 should be and Mental Is marked eumatic sv		19a. Informant's Name/Relationship (	Type, Print)	19b. M	Mailing Address (Street	et and Number	or Rural Route Nu	mber, City	,	, Zip Code)
6, ₹	1 and Health em 27 ther tr		Gwendolyn Newman	(Daughte	er 155	8 Peach W	alker I	r., Bowi	e,Md.	20716 .ocation - City o	y Tourn State
Baltimore,	permit, Pages 1 an Department of Heal Importent: If Item 2 any injury or other once.		1 Donation 5 □ Other (Specification 5 □ Other		ate cemetery,	pisposition (Name of crematory or other pi	lace)	/27/200!			
altir	mit. P partme porten jour	1	21. Signature of Funeral Service Lice		ALLING	22. Name and Add					virginia
ã	Depa Impo any is		mes El	uno	1	912 Third	St. N.	Tri-Stat W. Wash.	B. 6. 2	6685	
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	one cause on eac	th line.	t enter the mode of d	ying, such as c	ardiac or respirator	y arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a	ARDINE  as a consequence of  UPERT	ARRHTI	MARIA				Chisel and Beath
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	and trans	Examine	Cause (Disease or injury that initiated events resulting in death) Last	C	as a consequence of						
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9	tificate ig phy: as the	ledic		d							
Вох	eath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outco	me of pregnancy h 2 Fetal death	3 □Ectopic pregnan	icy			23d. Date of d	
	the dealy the all	yslcl	1 Yes 2 No	4□Pregnar 9□Unknow	nt at time of death m	5 Other (specify)			_	Month	Day Year
, P.O.	res that the de igned by the be detached		Part II. Other significant conditions of	ontributing to dea	th but not resulting in t	he underlying cause g	given in Part I.	23e. D	id tobacco	use contribute	to the cause of death?
rds	w requires been sign should be	ed by	STROKE					1	☐ Yes 2	. □ No 3 □ F	Probably 4 Unknown
Vital Records,	25 8	Completed						24a. W	as an stopsy	24b. Were a	autopsy findings available completion of cause of
E	T e se	Corr							orformed?	death?	
Vita	Physician: The this certificate ral director, pag	o Be	25. Was case referred to medical examiner?	Hospital:			thor	of Death (Check on		17-	Bowie
		$\vdash$	1 Yes 2 No 27. Manner of Death	28a. Date of (Month,		ne of 28c. Inj	4 L Nurs	sing Home 5 R	esidence be how inju	Other (Sp iny occurred	ecify) Health Ctr
ion	Attending r death, ector: After by the fune	atlo	1 Natural 5 Pending investigation	1	Day Year) Inji		□Yes 2□N	0			
Division	if or Attend after death Director: /	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of	f Injury - At home, farm , etc. <i>(Specify)</i>	n, street, factory, office	е	28f. Locatio City or	n (Street al Town, State	nd Number or I e)	Rural Route Number,
	e Hospitel or. 24 hours afte e Funerel Dire etely filled in b		29a. Certifier 1X Certifying Pt	vsicien. To the	st of my knowledge,	death occurred at the	time, date and	place, and due to	he cause(s	and manner a	as stated
	To the Hospitel or Attentwithin 24 hours after deatl To the Funerel Director: completely filled in by the	edical	(Check only 2 Medicel Exer	niner On the Bas and manne	is of examination and/	or investigation, in my	opinion, death	occurred at the tin	ne, date an	d place, and du	ue to the cause(s)
	To the within 2. To the complet	Σ	29b. Signature and title of certifier	111			nse number			ite signed (Mor	nth, Pay, Year)
•			1 /love X	NIN	لات	D	412	40	0	4/14	101
			30. Name and address of person who NORM AN SM	completed cause	of death (Item 23a) (To 2905	pe, Print) pn//Che	Ilville	RD #10	4	Baule	MD
	Sta Registr		31. Date filed (Month, Day, Year)	32. Reg	gistrar's Signature						20116
	riegisti	्र	APR 2 5 2005	Dealers	15 15034						

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of Marylan		artment of F			iene	ne.	1 6 5 10 10
	0.		1. Decedent's Name (First, Middle, Last)	-				2. Date of Deat	n	U)	3. Time of Death
	Physic /Medi		Roy F	atterso	מ			Month	Day	Year	9:45 PM
	Exami		4a. Facility Name (If not institution, give stre	eet and number)		4b. City, Town, o	or Location of Death	•	4c. County	of Death	1.13.
			Chesapeake 1	Hospice H	touse	Linthi	CLIDO			AA	0.0
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year Months Days	If Under 24 Hrs.	8. Date of Birth (Month, Day,	Vaasi		lace (State or Foreign
	Director		A VO. C.d. C. (6)	20F 83	Yrs.	Months Days	Hours Min.	6 21.		TEN	itry) IN
	pur *		Usual Residence of Decedent  10a. State 10b. County	140- 60							
	aryla shov	_	, , ,		y, Town or Lo					1	0d. Inside City Limits
	Ba-f	Director		L PE	ASADENA	1					1 ∑Yes 2 ☐ No
	with t		10e. Street and Number			10f. Zip Code		10	g. Citizen of V	Vhat Coun	itry?
	s 23	ra	421 MAGOTHY BRIDGE			21122			USA		
	er de Itam Derr	Funeral		Was Decedent Ever in U. Armed Forces?	.S. 13. \	Vas Decedent of H f Yes, specify Cuba	lispanic Origin? (Spe an, Mexican, Puerto	ecify Yes or No- Rican, etc.)		- Americ k, White,	
36	rs aft	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		□ Yes 2∏ No	Specify:		Specify		
21215-0036	72 hours after death with the Maryland "natural", or Itams 23a or 28a-f show ideal Examinat must be redified at	ed	15. Decedent's Educat		16a Dogge	lent's Usual Occup					
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212	d within giene. ir than "	E	Elementary/Secondary (0-12) -12-	College (1-4or 5+) -4-	TEAC		-,		EDITO A	TT 037	
	filed Hyg stha	BeC	17. Father's Name (First, Middle, Last)		IEA	лек	18. Mother's Name	(First, Middle, M	EDUCA'	- I- V A 1	
Maryland		To B	ROY PATTERSON SR.					ETH FINL		-/	
ary	d 2 should th and Mer 7 is marks traumatic	-	19a. Informant's Name/Relationship (Type,	Print)	19b. Mailin	g Address (Street	and Number or Rura			State 7in	Code
Š			CAROLYN LADEJI(DA	UGHTER)							AND 21215
ē,	- T 6	4	20a. Method of Disposition	20b. P	lace of Dispo	sition (Name of	Г		Oc. Location -		
Ë			1 ☐ Burial 2 ☐ Cremation 3 ☐ Rem  `4 ☐ Donation 5 ☐ Other (Specify)	Oval II OIII State		natory or other place	4-22-	2005 P	AT TOTALOT		A DAZE A MID
Baltimore	# 는 <b>보</b> 근 .		21. Signature of Funeral Service Licensee]				ss of Facility PHI		MEDAT I	KE, M	ARYLAND
ä	Depa Depa Impo any i	6.3	Invath	() His	17 رو	21-27 N.	MONROE S'	T. BALTI	MORE I	MARVI	AND 21217
			23a. Part1. Enter tile disease, or complicat	ions that caused the death							Approximate
	Physician		Shock, of the Attailure. List only one (	ause off each line.	201/12	Carlo 211	1 1	Discar			Interval Between Onset and Death
	/Medical	ľ.	resulting in death)	Due to (or as a consequ				01800		-	
	Examiner				arter	a disc	erse				
		Jer	Sequentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	uence of):	1					
9/	cutac nd ransi	Examiner	that initiated events	Cardion	your	they					
o	an al	EX	resulting in death) Last	Due to (or as a consequ	ience of):	20.1					
8760,	cate be executad physician and the burial-transit	Physician/Medical	d	Drabele	o p	rells m	0				
	artifica ing pl	Med	IF FEMALE:	_							
Вох	death certific e attending p od for usa as	an/	23b. Was decedent pregnant in the past 12 months?	If yes, outcome of pregnar 1 ☐ Live birth 2 ☐ Fetal		Ectopic pregnancy			23d. Date		у
<u>.</u>	e deg	sic	1 Yes 2 No	4☐Pregnant at time of de 9☐ Unknown		Other (specify)			Mon	th [	Day Year
P.O.	that the death led by the atter detached for i	F.									
JS,	20 0	by	Part II. Other significant conditions contrib	uting to death but not resu	liting in the un	derlying cause give	en in Part I.				cause of death?
010	w require been signal	ted	1.	1.1.7				1 🗆 Yes	2 □ No :	3 🗌 Proba	bly 4 Monknown
ec	law lasb	ple	lingstor hear	failure				24a. Was an autopsy	24b. W	ere autop	sy findings available pletion of cause of
	The cata h	Completed by		$\nu$				performe	ed?// de	eath?	
Vital Record	Physician: The la r this certificata has ral director, page 2	Be	25. Was case referred to medical examiner?				26. Place of Death				
	hysi this c	၉	1 Yes 2 No Hosp	1 □ Inpatient 2 □ E	ER/Outpatient		4   Nursing Hom	ne 5 🗌 Residen	ce 6 Tother	(Specify)	HOSPICE
Ē	ing F	on:	27. Mann of Death  1 Natural 5 Pending	8a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work	at 2	8d. Describe how	injury occurre	d	7
si Si	ttand death stor: / the fr	cat	2 Accident investigation				res 2 □No				
Division of	l or At after d Diraci J in by	Certification:	4 Homicide determined	<ol> <li>Place of Injury - At hor building, etc. (Specify)</li> </ol>	me, farm, stre )	et, factory, office	2	8f. Location (Stre City or Town,	et and Number State)	r or Rural	Route Number,
	urs a										
	To the Hospital or Attanding Ph within 24 hours atter death. To tha Funaral Director: After th completely filled in by the funeral	edical	29a. Certifier  (Check only one)  1 Certifying Physicie 2 Medical Exeminer:	on: To the best of my know On the basis of examinati	vledge, death on and/or inv	occurred at the timestigation, in my op	e, date and place, a pinion, death occurre	nd due to the cau d at the time, date	se(s) and man	ner as sta	ted. he cause(s)
	To the within 2 To tha complet	Mec	29b. Signalure and little of certifier	and manner stated.		29c. License					
	± ₹ 5		1 4 The A	Bur air	).			290	. Date signed	(wonth, D	ay, rear)
,	10						2820				
	W		3708 mount				10-13				
	Sta	0	3708 Mount	32. Registrar's Signatu	re coso	cienci	mD 3	11122			
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John T. Ridgley, Jr.  ACUTE HEALTH-CAIPE  S. Actives HEALTH-CAIPE  S. A	ent of Health and Mental Hygiene ate of Death Reg. No. 2005   388	1 - State Certification Certif
Actional Stammans    Actional T.   Actional Stammans    Actional T.   Actional Stammans    Actional T.   Actional Stammans    Actional T.   Actional Stammans    Actional T.   Actional Stammans    Actional T.   Actional Stammans    Actional T.   Actional Stammans    Actional T.   Actional Stammans    Actional T.   Actional Stammans    Actional T.   Actional T.   Actional Stammans    Actional T.   Actiona	Month Day Year	1. Decedent's Name (First, Middle, Last)  Physician  The Physician
ST. AGUES ITEALTUCATIONS    The control of the cont		/Medical John T. Ridgley, Jr.
See See Servey Number 216-24-3798 8 20 M 25 F 7.40 (in yet, but before the property of the pro	MA Assessed a services	
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The part of the	Jan 31, 1933 Maryland	Director 210-24-3798
The part of the pa	10d. Inside City Limits	0
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The part of the pa		1223 Tugwell Drive
The part of the pa	cedent of Hispanic Origin? (Specify Yes or No- pecify Cuban, Mexican, Puerto Rican, etc.)  14. Race - American Indian, Black, White, etc.	9 E 1 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces 13. Was If Ye
The part of the pa	2No Specify: Specify: White	3 \(\text{ZWidowed 4}\) \(\text{Divorced}\) \(\text{If Yes, Give}\) \(\text{Year or Dates:}\)
The part of the pa	sual Occupation 16b. Kind of Business/Industry	2 15. Decedent's Education 16a. Decedent's (Specify only highest grade completed)
The part of the pa		Elementary/Secondary (0-12) College (1-4or 5+)
12 Suma   2   Granution   3   Demonstrative   Licenses   22. Name and Address of Facility   Hubbard Funeral Home, I   4107 Wilkens Avenue, Baltimore, Marylan   4107 Wilkens Avenue, Baltimore, Mary		P S T T T S S S S S S S S S S S S S S S
12 Suma   2   Granution   3   Demonstrative   Licenses   22. Name and Address of Facility   Hubbard Funeral Home, I   4107 Wilkens Avenue, Baltimore, Marylan   4107 Wilkens Avenue, Baltimore, Mary		John T. Ridgley, Sr.
12 Suma   2   Granution   3   Demonstrative   Licenses   22. Name and Address of Facility   Hubbard Funeral Home, I   4107 Wilkens Avenue, Baltimore, Marylan   4107 Wilkens Avenue, Baltimore, Mary	uss (Street and Number or Rural Route Number, City or Town, State, Zip Code)	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Ac
12 Suma   2   Granution   3   Demonstrative   Licenses   22. Name and Address of Facility   Hubbard Funeral Home, I   4107 Wilkens Avenue, Baltimore, Marylan   4107 Wilkens Avenue, Baltimore, Mary		Tami Cillo / Daughter 1111 Oa
23. Part : Algor the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.  23. Part : Algor the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.  23. Part : Algor the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.  23. Part : Algor the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.  24. Due to (or as a consequence of):  25. PNEUMICK! A  25. Due to (or as a consequence of):  26. Due to (or as a consequence of):  27. Due to (or as a consequence of):  28. Due to (or as	r other place)	and the second of the second o
23. Part : Algor the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.  23. Part : Algor the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.  23. Part : Algor the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.  23. Part : Algor the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.  24. Due to (or as a consequence of):  25. PNEUMICK! A  25. Due to (or as a consequence of):  26. Due to (or as a consequence of):  27. Due to (or as a consequence of):  28. Due to (or as		*4 Donation 5 Other (Specify)  New Cathedr
Physician (Medical Examiner)  Sequentially list conditions, and participated and participat	Wilkens Avenue, Baltimore, Maryland 21229	Jehn Onde 410
Color   Characteristics   Color   Characteristics   Characterist	ode of dying, such as cardiac or respiratory arrest, Approximate Interval Between	
Due to (or as a consequence of):    PACHIMINET   PACHIMICA   PACHI	Onset and Death  Onset Co	disease or condition  (Modical resulting in death)
Sequentially list conditions.  Due to (or as a consequence of):  Due to (o	24 WEEKS	Due to (or as a consequence of):
To be contained to the complete to the control of the complete to the control of the complete to the control of the complete to the control of the complete to the control of the complete to the control of the contr	7 1 1	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):
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9   Unknown   9		Due to (or as a consequence of):
9   Unknown   9		physical phy
9   Unknown   9	22d Date of deliver	IF FEMALE: 23b Was decadent proposit 23c. If yes, outcome of pregnancy
9   Unknown   9	pregnancy	in the past 12 months?    Comparison   Compa
SOURCE STRUCTIVE PRIMODARY DISEASE  1 Page 1 Page 2 No 3 Probably  24a. Was an autopsy find an autopsy find a supply performed?  25. Was case referred to medical examiner?  1 Page 2 No 3 Probably  24a. Was an autopsy find a supply performed?  1 Page 2 No 3 Probably  24b. Were autopsy find a supply performed?  1 Page 2 No 3 Probably  24a. Was an autopsy find a supply performed?  1 Page 2 No 3 Probably  24b. Were autopsy find a supply performed?  1 Page 2 No 3 Probably  24b. Were autopsy find a supply performed?  25. Was case referred to medical examiner?  1 Page 2 No  27b. Were autopsy find a supply performed?  27c. Manner of Death  27d. Manner  27d. Death  27d. Death  27d. Death  27d. Death  27d. Death  27d. Death  27d. Death  27d. Death  27d. Death  27d. Deat		e ta Se se se se se se se se se se se se se se
The state of the s	cause given in Part I. 23e. Did tobacco use contribute to the cause of death?  1 Pres 2 No 3 Probably 4 Unknown	Part II. Other significant conditions contributing to death but not resulting in the underly
The state of the s	24a. Was an 24b. Were autopsy findings available	ALCOHOLIC LIVER CIRCHOSIS
The state of the s	autopsy prior to completion of cause of death?	HEPATIC FAILURE
The state of the s		U 25. Was case referred to medical examiner?
1   Matural   2   Accident   3   Suicide   4   Homicide   4   Ho	OOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)	1 Yes 2 No 1 patient 2 ER/Outpatient 3
3 Suicide 4 Homicide 3 Suicide 4 Homicide 3 Suicide 4 Homicide 4 Homicide 4 Homicide 4 Homicide 4 Homicide 5 See Place of Injury - At home, farm, street, factory, office 5 See Place of Injury - At home, farm, street, factory, office 6 Could not be building, etc. (Specify)  288. Place of Injury - At home, farm, street, factory, office 6 Could not be building, etc. (Specify)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, P18614)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  MARIA CARMELA N. ROSALES, MO 900 S. CATON AVE 21229 BAUTIMORE, MIN		The second of th
29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier  29b. Signature and title of certifier  29c. License number  29c. License number  29d. Date signed (Month, Day, PISCI4)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  MARIA CARMELA N. ROSALES, MO 900 S. CATON AVE 21229 BAUTIMORE, MI		3 Suicide 6 Could not be
Marin Carmela N. Propales MD P18614  APRIL 23, 2005  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  MARIA CARMELA N. ROSALES, MO 900 S. CATON AVE 21229 BALTIMORE, MI		building, etc. (Specify)
Marin Carmela N. Propales MD P18614  APRIL 23, 2005  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  MARIA CARMELA N. ROSALES, MO 900 S. CATON AVE 21229 BALTIMORE, MI	d at the time, date and place, and due to the cause(s) and manner as stated. xn, in my opinion, death occurred at the time, date and place, and due to the cause(s)	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occur (Check only one)
Marin Carmela N. Propales MD P18614  APRIL 23, 2005  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  MARIA CARMELA N. ROSALES, MO 900 S. CATON AVE 21229 BALTIMORE, MI	9c. License number 29d. Date signed (Month, Day, Year)	29b. Signature and title of certifier
MARIA CARMELA N. ROSALES, MO 900 S. CATON AVE 21229 BALTIMORE, MI		marin Carmela n. Rosalis . MD
	S. CATON AVE 21229 BALTIMORE, MO	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
Registrar APR 2 5 2005		State Registrar APR 2 5 2005 2. Registrar's Signature

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Daniel Richard 8 on

				Type or Pri								_		
		1	1 - For State Registrar	Otato or m	a. y (a.)	•	tificate o				Reg. No	11115	138	81
	H		Decedent's Name (First, Middle, L	ast)						2. Date of De		x Year	3. Time o	of Death
	Physici: /Medic		Daniel E. Rich	nardson						April	12	2005	- 110	PM
	Examin		4a. Fecility Name (If not institution, gi Maryland C	reneral	Hos	oital.	4b. City, Town Balti	nore	Ci	ty		. County of De	a	/
	Funeral Director		218-22-2786	Sex 7. Ag 1XM 2☐F	e (In yrs. I	ast birthday) Yrs.	Months Day		Min.	a. Date of Bi (Month, Di Feb 5	ay, Year)		irthplace <i>(State Country)</i> Marylan	
	and ow		Usual Residence of Decedent  10a. State 10b. County		10c. City	, Town or Loc	cation						10d. Inside C	City Limits
	death with the Maryland ms 23e or 28a-f show must be rodified at	tor	Maryland n/a		] ]	Baltimo	ore						1 XYes	2 □ No
	or 288	Director	10e. Street and Number				10f. Zip Code				_	tizen of What (		
	ath w	rai	1605 Cole Street					21223				nited S		
	be filed within 72 hours after death with the Marylan Hygiene. Hygiene. do ther than "natural", or Items 23e or 28e-f show event, the Medical Examinat must be rediffed at	by Funerai	11. Marital Status  1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☒ If Yes, Give Year or Dates:		i	Vas Decedent o Yes, specify Co □ Yes 2 🔼 N			ecify Yes or N Rican, etc.)	0-	14. Race - American Indian, Black, White, etc. Specify: White		
215-0036	72 ho	ted	15. Decedent's l (Specify only highest g	Education	16a. Decedent's Usual Occupation (Give kind of work done during most of wo					ina	16b. K	ind of Busines	s/industry	
1717	filed within 72 Hygiene. Ither than "natent, the Medic	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)	life. D	oo NOT use ret ainter	ired)			T	ruck Re	epair	
Ě		To Be C	17. Father's Name (First, Middle, Las Unknown	st)				18. Mothe		e (First, Middle KNOWN	(First, Middle, Maiden Surname)			
Mary	s 1 and 2 should f Health and Men item 27 is marks other traumetic	-	19a. Informant's Name/Relationship				g Address (Stre							
	and 2 ealth n 27 i		Shirley L. Richa	ardson / Wi			Cole St				,			
Baltimore,	80=5		20a. Method of Disposition 1    Burial 2 □ Cremation 3		20b. P	lace of Disposemetery, crem	sition (Name of natory or other p	l l		Date		ocation - City o		
<u>=</u>	it. Pa intmen intent: njury		' 4 ☐ Donation 5 ☐ Other (Spec		Lo		Park Co		4/22/	/2005	Woo	dlawn,	Marylar	nd
g	permit. Departr Imports any inju		21. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229											
-			23a. Part1. Enter the disease, or con shock, or heart failure. List only	mplications that caused	d the death								Approxima Interval Be	te
ı	Physician		Immediate Cause (Final disease or condition		mo	nia							Onset and	
	/Medical Examiner		resulting in death)	Due to (or as	a consequ	pence of):	C	Can	ce	R				
Ŧ	n ≃	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequ	uence of):	·							
V	executed an and rial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as	a consequ	ience of):								
Ď,				,	a consequ	201100 01).								
9/89	fficate g phys	edic		d										
O. Box	s that the death certificate be es ned by the attending physician s detached for use as the buria	by Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal	death 3 🗆	Ectopic pregnal Other (specify)					23d. Date of delivery Month Day Yea		Year
ų. J	requires that the een signed by th hould be detache	y Pt	Part II. Other significant conditions	contributing to death b	ut not resu	ulting in the un	derlying cause	given in Part I	I.	23e. Did	tobacco	use contribute	to the cause of	death?
rds	w requires to been signed should be	ed b	Stroke							1 🗆	Yes 2	□No 3□F	Probably 4 🗗	Unknown
	aw S S	Completed								24a. Was		24b. Were a	autopsy findings completion of c	available
	ate pag	Com								perf 1 ☐ Yes	ormed? 2 No	death?		
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:				Thor		n (Check only				
o	e id	: To	1 ☐ Yes 2 No  27. Manner of Death	1 Minpati		ER/Outpatient 28b. Time of	3 □ DOA   28c. In	4 L N		me 5 Res 28d. Describe		6 □Other (Sp	ecify)	
	Attending r death. actor: After by the fune	ition	1 Natural 5 ☐ Pending 2 ☐ Accident investigate	(Month, Da	y Year)	Injury	V	Vork? □Yes 2□				,		
	o it de	Certification:	3 Suicide 6 Could not determine	be 390 Place of In			eet, factory, office	ce		28f. Location ( City or To	(Street ar own, State	nd Number or F	Rural Route Num	nber,
	Hospite 4 hours Funere ely fille	Medical C	29a. Certifier 1 Certifying F (Check only one)	Physician: To the best eminer: On the basis of and manner st	f examinat	wledge, death tion and/or inv	occurred at the estigation, in m	time, date an y opinion, dea	nd place, ath occurr	and due to the red at the time.	cause(s , date and	and manner a d place, and du	as stated. ue to the cause(s	s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	~ 10				ense number	f j			te signed (Mor	oth, Day, Year)	
			Pobert	Ell,	MI	2	8	954	/		4	119/0	25	
	2		30. Name and address of person wh	completed cause of	leath (Item	23a) (Type 1	Print) /a	nd 6	sien	eral	M	USpite	al_	
	Sta Registr		31. Date filed (Month, Day, Year) APR 2 5	2005 32. Redistr	ar's Signa	ture	barte					/		

State of Maryland / Department of Health and Mental Hygiene [ ] [ ] 5 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month 752 PM **Physician** RAU JOSEPHINE ELSIE 05 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE BALTIMORE MEDICAL CENTER BALTIMORE (-REATER If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 3 Months Hours 1 ☐ M 2 🖾 F Yrs. N/A April 18,2005 Maryland Director Usuat Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 28a-1 show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.
Important: if itam 27 Is marked other than "natural", or itams 23s or 28s-1 show any injury or other treumatic event. The Medical Examiner must be multilised at once. 1 TYes 21 No Director Maryland Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5910 Edmondson Avenue 21228 U.S.A. Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 No Il Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: Completed by 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) N/A N/AN/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Mark David Rau Marcia Antkowiak 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mark David Rau (Father) 5910 Edmondson Ave Catonsville, Maryland 21228 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 5 Other (Specify) Lorraine Park Cem. 4-23-2005 Woodlawn, Maryland ⁴ 4 ☐ Donation 22. Name and Address of Facility
Witzke Funeral Home of Catonsville, Inc.
1630 Edmondson Avenue Catonsville, MD 21228 21. Signature neral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) HYPOXIC ISCHEMIC HAMORE DAYS **Physician** ENCEPHALOPATHY IN UTERO /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be execused physicien and s the burial-transit Due to (or as a consequence of): Box 68760 Be Completed by Physician/Medical IF FEMALE: for use 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🔀 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) Records, P.O. cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2Q No Division of Vital 25. Was case referred to medical examiner? After this certific funeral director. 26. Place of Death (Check only one) Hospital: 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 Ø No Medical Certification; To 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27, Manner of Death 28d. Describe how injury occurred 5 Pending investigation 1 Natural within 24 hours after death. To the Funaral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🔲 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 / Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) Dr. make 121/05 DOD 46156 Taxe 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) A. PANE 6BMC 6701 N CHARLES ST. BALTIMORE MD Goarde 31. Date filed (Month, Day, Year) 32 Registrar's Signature State APR 25 130000 Registrar

			For State Registrar	State of Ma	aryland /		artment rtificate			ınd M		giené	2005	13	883
	Physicia /Medic Examin	al	Decedent's Name (First, Middle     S     4a. Facility Name (If not institution	Rob	iNSC	N	4b. City, To	own, or	Location o	f Death	April	Day 14	Year  200  County of Dea	5 11	of Death  AM
	Funeral Director		5. Social Security Number 239-46-3648		e (In yrs. last	birthday) Yrs.	If Under 1		Height If Under 2 Hours		8. Date of Birt (Month, Da) 10-03-19	h y, Year)			e or Foreign
	D	tor	Usual Residence of Decedent  10a. State 10b. County	Georges	10c. City, T						10 03 17		THOLE	10d. Inside	City Limits
	with the	Direc	10e. Street and Number 505 Suffolk Avenue	Apt 106			10f. Zip C	ode 20743	}			-	zen of What Co	ountry?	
036	d within 72 hours after death with the Maryland jiene. I than "natural", or Itams 23a or 28e-f show The Medical Evandrat must be notified at	by Funeral Director	11. Marital Status  1 Never Married 2 Marr 3 Widowed 4 Divorced	12. Was Decedent I Armed Forces?			Was Deceder If Yes, specify	_	spanic Orig n, Mexican Specify:	gin? (Spe , Puerto	cify Yes or No- Rican, etc.)	USA  14. Race - American Indian, Black, White, etc.  Specify: Black			
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yland ;		To Be C	to 17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Sumame, 18. Mother's Name (First, Middle, Maiden S									Zin Codo)			
Baltimore, Mary			Valencia Swain/ Date 20a. Method of Disposition  1 X Burial 2 □ Cremation  4 □ Donation 5 □ Other (S	ighter 3 □Removal from State	20b. Place	.038 B e of Dispo etery, crei	acon Str esition (Name matory or other	reet o of er place	Durhar	m, NC	27703	20c. Lo	cation - City or	Town, State	
Baltil	permit. Pages: Department of H Important: If Ite any injury or of		21. Signature of Funeral Service	Licensee	)	Wy Wy		Addres eral	s of Facility Home	638 N	. Gilmor	Stre	et Balto,		217
	Physician /Medical Examiner	10	23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if you leading to immediate	a. Due to (or as	a consequen	ce of):	er the mode	of dying	, such as	cardiac o	r respiratory ar	rest,		Approxir Interval Onset at	
8/60,	certificate be executed ording physician and use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	a consequen	ce of):								405	
O. Box 6	death e atter id for u	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ ₩o 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal de	ath 3[	Ectopic preg						23d. Date of de Month	livery Day	Year
ecords, P	The law requires that the to be been signed by the bage 2 should be detache	by	Part II. Other significant condition	ons contributing to death b	ut not resultin	ng in the u	nderlying cau	ise give	n in Part I.		~		se contribute to	o the cause or the cause of the	
Vital Rec		e Completed	25. Was case referred to medical						26 Place	of Death	24a. Was autop perfo	rmed3 No	death?	utopsy findin completion o	gs available if cause of
ō	ding Phys h. After this funeral dir	To B	examiner? 1	Hospital: 1  Inpatie 28a. Date of Inju (Month, Da)	ont 2□ER ry 28 y Year)	/Outpatier b. Time o Injury		c. Injury Work	□ 4□Nu	rsing Hor		dence (	6 □Other (Spe y occurred	ocify)	
Division	oital or Attendurs after deathurs Diractor:	Certification;	3 Suicide 6 Could determ	ined 286. Place of Injury	c. (Specify)					U	City or Tox	vn, State			umber,
	To the Hospital within 24 hours a To the Funeral completely filled	Medical	29a. Certifier (Check only one) 2 ☐ Medical 2 ☐ Medic	eg Physician: To the best Examiner: On the basis of and manner sta	f examination	idge, deat and/or in	vestigation, ir	n my op	e, date and inion, deat	d place, a	ed at the time,	date and	e signed (Mont	e to the caus	
ı	4		30. Name and addr ss of person	co offevolcal e of d	leath (Item 23	Ba) (Type,	Print)	5	5	75	1	. 1.	- 15	100	3 2070
7	Sta Registr		31. Date filed (Month, Day, Year)	R 9 5 2005	ar's Signature	88C	un	nap	oles	LNU	La	mn	an	Vr LD	10.10

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month 10 PM Rahman Muhammad Abdul 04 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner SOOD DAKARITAN HODDI 5601 LOUH BRUEN BLVO BALTIMORE 6. Sex 1**¼¼** 2□ F If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 65 Yrs. **Director** 219-32-8383 MD 19 Usual Residence of Decedent 10a. State Show 10b. County 10c. City, Town or Location 10d. Inside City Limits other treumatic event, the Madical Examiner must be notified at 1 Yes 2 No Director MD NA Baltimore 28e-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? , or items 23a or 21244 U.S.A. 3406 Washington Ave 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes X☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 Divorced Black "naturel" ted 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 7: h and Mental Hygiene. 7 Is marked other than "n Elementary/Secondary (0-12) College (1-4or 5+) 12th grade Assembler General Motors 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Mallory Rice Mary Dokins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If item 27 Is n any injury or other treun once. 109 North Broadway 2nd Fl, Balto, Md 21231 LaShona Rahman-Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State ☐Donation 5 ☐ Other (Specify) Memorial Park 4/26/05 Randallstown, 21. Sign: ure of Funeral Service Licenses 22. Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore, Md 21215 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failing. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician HERRT CONGESTIVE FRILURE disease or condition resulting in death) /Medical Examiner CARDIOMYOPATHY SCHEMIC S. penticly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): ROLAR Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 5 Other (specify) P.O. 9□ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 2 Inknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 ☐ Yes 2 ☐ No 1 🗌 Yes 2 No or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Impatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 ☑ No Other: Certification: To 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 THomicide within 24 hours a
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completely filled 1 🗹 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

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Registrar

31. Date filed (Month, Day, Year) APR 2 5 2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

11500 SAMARITAN HOSPIT 37 Registrar's Signature

RE5000

29d. Date signed (Month, Day, Year)

APRIL

			State of Maryland / Department of Health and I	_	_	10005
			1 - For Registrar Certificate of Death		Reg. No.	13885
	Physici	an	1. Decedent's Name (First, Middle, Last)	2. Date of Dea	Day Year	3. Time of Death
	/Medic	al	VIRGINIA M. IZA USCHER  4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death		4c. County of Oeatl	3.30 PM
	Examin	er	NORTH ARUNDEL HOSPITAL GLENBURNIE			RUNDEL
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth Month, Day	9. Birtl	nplace (State or Foreign untry) ryland
<b>(2)</b>	Director		213-12-2610 1 M 2 V F 83 Yrs. Months Days Hours Min.  Usual Residence of Decedent	Nov.Ub,	,1921 Ma	ryland
0	yland how		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	8a-1 e	ctor	Maryland Anne Arundel Pasadena			1 Yes 2 No
1 el VIRGINIO d 21215-0036	within 72 hours after death with the Maryland ane. than "natural", or items 23s or 28s-f ehow is Madical Exam are much be notified at	Funeral Director	10e. Street and Number 8476 Greenway Road 21122		10g. Citizen of What Co U.S.A.	intry?
2	items 2%	nera	11 Marital Cratus 12 Was Decedent Ever in ILS 13 Was Decedent of Hispanic Origin? (S	pecify Yes or No-	14. Race - Ame Black, White	
.> <sub>∞</sub>	s after , or ite	by Fu	Armed Forces?  1 Never Married 2 Married 1 Yes 2 No 1 Yes 2 No Specify:  3 Widowed 4 Divorced Year or Dates:		Specify: Wh	
8	s 1 and 2 should be filed within 72 hours after Health and Menial Hygiene. Item 27 is marked other than "natural, or i other traumatic event, the Mudical Exart.	ted b	15 Decedent's Education 16a Decedent's Usual Occupation		16b. Kind of Business/	
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and	2 should be filed within and Menta! Hygiene. Is marked other than aumatic event, Ita Ma	To Be		Edenfi		
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ح ≥	and 2 ealth a n 27 is		Margaret Powers (Daughter) 8436 Geneva Road, Pas	_		
RAUSCH Baltimore, Maryland	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra 2002.		20a. Method of Disposition 20b. Place of Disposition (Name of cemetary, crematory or other place)  20b. Place of Disposition (Name of cemetary, crematory or other place)		20c. Location - City or	
次 草	artmer ortant Injury		*4 □Donation 5 □Other (Specify) Glen Haven Mem Park 04-2  21. Signature of Funeral Service Licensee 22. Name and Address of Facility 1			
Ba	Pen Pen Pen Pen Pen Pen Pen Pen Pen Pen		McCully-Polyniak F 3204 Mountain Road	uneral H , Pasade	Home P.A. ena, Maryla	nd 21122
			23a art1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.	or respiratory arr	rest,	Approximate Interval Between
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68	rtificate ng phy as the		IECEVALE.			
Вох	ath cei ittendir or use	ian/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy		23d. Date of deli Month	very Day Year
o.	that the death certifica ed by the attending ph detached for use as th	ysic	1 Yes 2 No 9 Unknown 5 Other (specify)			
ر. ح	es that igned b	by Physician/Med	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did to	bacco use contribute to	the cause of death?
ord	w require been sig should b		ANEMIA	1 XY	′es 2 No 3 Pr	obably 4 Dunknown
Division of Vital Records, P.O. Box	e law r has bu ge 2 st	Completed	ATRIAL FIBRICATION	24a. Was a autop: perfor	an 24b. Were au prior to death?	topsy findings available completion of cause of
la l	in: Th ificate or, pag		25. Was case referred to medical 26. Place of Dec		2 No 1 ☐ Yes	25 No
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n o	ing Ph iner th	on:	27. Manner of Death  1   Natural 5 □ Pending (Month, Day Year)  28a. Date of Injury 28b. Time of Injury at Work?		low injury occurred	
isio	death.	icati	2 Accident investigation   M   1 Yes 2 No   3 Suicide   6 Could not be determined   28e. Place of Injury - At home, farm, street, factory, office	28f. Location (S	Street and Number or Ru	ral Route Number,
Div	el or A s efter il Dire	Certification:	4 Homicide determined building, etc. (Specify)	City or Tow		
	To the Hospitel or Attending Physician: The law requires that the death certifical within 24 hours effer death.  To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the		29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place	e, and due to the curred at the time, o	cause(s) and manner as date and place, and due	stated. to the cause(s)
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	CA CA		1 Sami lain Mp D00618	32	4/19/05	
1	0		30. Name and address of person who completed cause of death (Item 23a) (Type, Print).	# 21	6/1	
	<u></u>	ate.	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Same 30   Haspital 9-  31. Date filed (Month, Day, Near) 32. Registrar's Signature  APR 2 5 2005	210	/6/	
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DHMH 17 Rev 1/2001

			1 - State Amend Item Registrar	State of 8 per info	Marylan ormant	d / Depa <b>G845</b> e	artment of H 711172at9514	ealth a <b>9</b> €ath	and Mental H	ygiene	005	13886		
			1. Decedent's Name (First, Middle					-	2. Date of Month		Year	3. Time of Death		
	Physicia /Medic		Selena	Robins	ON_						2005	11:30 AM <sup>M</sup>		
	Examin		4a. Facility Name (If not institution	•	,		4b. City, Town, or		f Death	4c. 0	County of Death			
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П	Funeral Director		5. Social Security Number 228–20–9986	6. Sex 7. 1 ☐ M 2 💢 F	Age ( <i>I</i> n <i>yr</i> s. 76	Yrs.	Months Days	Hours	Min. (Month,	Birth Day, Year) 1926	923 9. Birth	place (State or Foreign intry) Cginia		
			Usual Residence of Decedent						000	, 1920	, , , , , , ,	ginia		
	nylanc how		10a. State 10b. County			y, Town or Lo						10d. Inside City Limits		
	Ba-f s	Director	MD			Baltimo	ore			- <del></del>		1 X Yes 2 □ No		
	or 28	Dire	10e. Street and Number				10f. Zip Code			10g. Citiz	en of What Cou	intry?		
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	item item	Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Marri	12. Was Decede Armed Force ed 1 \( \subseteq Yes 2	es?	.5.	If Yes, specify Cuba	n, Mexican	gin? (Specify Yes or , Puerto Rican, etc.)	10-	Black, White			
936	urs af	þ	3 ¼ Widowed 4 □ Divorced	If Yes, Give Year or Date			1□ Yes 2X No	Specify:			Specify: b.	lack		
Ŏ	72 ho	ted	15. Decedent (Specify only highes	's Education			dent's Usual Occupa		of working	16b. Kin	d of Business/Ir	ndustry		
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2			17. Father's Name (First, Middle,				teache		r's Name (First Midr	_ i	ducatio	DΠ		
anc	tad be	) Be	Samuel Davis	Lasij					r's Name (First, Middle, Maiden Sumame) stelle Dodson					
Maryland 21215-0036	permil. Peges 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heelth end Mental Hygiene. Important: if item 27 is marked other then "natural; or items 23a or 28a-f show any injury or other treumatic event, it a Medical Examinar must be notified at once.	ဥ	19a. Informant's Name/Relationsl	nip (Type, Print)		19b. Mailir	ng Address (Street a	and Numbe	r or Rural Route Nur	nber, City or	Town, State, Zi	ip Code)		
Z			Julia Stovel/s	ister		1 Ki	ska Court	Rand	allstown,	MD 2	1133			
re,			20a. Method of Disposition				sition (Name of matory or other place	e)	Date	20c. Loc	ation - City or T	own, State		
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			23a, Party. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Batwee											
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Вох	death certific e attending p id for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	ome of pregnate		☐Ectopic pregnancy			2;	3d. Date of deliv	,		
	0 0 0	sicia	in the past 12 months?		nt at time of c		Other (specify)			-	Month	Day Year		
P.0	that the d	Phy	9 ☐ Unknowh  Part II. Other significant condition	ne contributing to do	th but not ros	culting in the u	adarhina causa anu	on in Part I	23e Di	d tobacco us	e contribute to	the cause of death?		
S,	se ig	l by	Alzheimer	demen	1.	during in the d	riderly ring dadae give	SITH TO WILL.		_Yes 2□		bably 4 DUnknown		
Ö	w requir	ompleted	711211011110		,,,,				24a. W	ac an	24h Were aut	opsy findings available		
Rec	e lav	mp							au pe	topsy rformed?	prior to co death?	ompletion of cause of		
la		e Co	25. Was case referred to medical					26 Place	of Death (Check on)		1 🗆 Yes	2 No		
of Vital Record	Physician: this certific ral director.	To B	examiner? 1 ☐ Yes 2 No	Hospital: 1 Ing	patient 2	ER/Outpatier	nt 3 DOA Othe	25	rsing Home 5 Re		X ther (Speci	ity) Assisted		
			27. Manner of Death Natural 5 Pendin	28a. Date of	Injury Day Year)	28b. Time o	f 28c. Injury	at	28d. Describ			LIN'S		
<u>Sio</u>	Attending in death.  octor: After by the fune	atic	2 Accident investig	ation			M 1 🗆 '	Yes 2 ☐ î	No			racity		
Division	or Att	Certification:	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ		if Injury · At h g, etc. <i>(Speci</i>	ome, farm, sti fy)	reet, factory, office		28f. Location City or 1	(Street and Town, State)	Number or Rui	ral Route Number,		
	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu		29a. Certifier Certifyin	g Physician: To the b	est of my kny	owledne deat	h occurred at the time	ne date and	d place, and due to the	ne cause(s) s	and manner as	stated		
	the Hos hin 24 ho the Fun npletely	edical	(Check only 2 Medical one)	Examiner: On the bas and manne	is of examina	ation and/or in	vestigation, in my of	pinion, deat	th occurred at the tim	e, date and p	place, and due	to the cause(s)		
	To the within To the comp	ž	29b. Signature and title of certifier	7			29c. License	number	-0-	29d. Date	signed (Month	, Day, Year)		
				-				61	185	4,	118/0	)5		
			30. Name and address of person	who completed cause	of death (Itel	m zda) (Type,	Print)	0	/1 0	-1	MIN	1225		
			31. Date filed (Month, Day, Year)	monds (	gistrar's Signa	>TC	5-6	5000	shlyn Pe	irh,	1106	1225		
	Sta Registr		APR 2 5 200		J.	Soule	A		)					

			1 - For State of Maryla		artment of F			giene 0 0 5	13887	
	Physici /Medic		Decedent's Name (First, Middle, Last)  JAMES JOSEPH SPEAL				2. Date of Dea Month APRIL	Day 2005		
	Examin		4a. Fecility Name (If not institution, give street and number)			r Location of Death		4c. County of C		
	Funeral		NORTH ARUNDEL HOSPITAL  5. Social Security Number 6. Sex 7. Age (In yrs	s. last birthday)	GLEN BUR		8. Date of Birth	ANNE ARUNDEL  9 Birthplace (State or Foreign		
	Director		217.20.0458 XX <sup>M 2□ F</sup> 78 Usual Residence of Decedent	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day SEPT 22	, 1926	Birthplace (State or Foreign Country) MD	
	arylane show	<u>.</u>	10a. State 10b. County 10c. C	City, Town or Lo	ocation				10d. Inside City Limits	
	the Ma	Director	MD ANNE ARUNDEL G	GLEN BU	RNIE 10f. Zip Code			On Citions of Miles	1 Tes 2 No	
	3a or	ום	287 THELMA AVE.		2106	.1	'	log. Citizen of What <b>USA</b>	t Country?	
336	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itams 23e or 28e-f show any injury or other traumatic event, I're Medical Exertifier must be notified at ADRE.	by Funeral	11. Marital Status  1 Never Married  3 Widowed 4 Divorced  12. Was Decedent Ever in the Armed Forces?  12. Was Decedent Ever in the Armed Forces?  12. Was Decedent Ever in the Armed Forces?  13. Was Decedent Ever in the Armed Forces?  14. Was Decedent Ever in the Armed Forces?  15. Was Decedent Ever in the Armed Forces?  16. Was Decedent Ever in the Armed Forces?  17. Was Decedent Ever in the Armed Forces?  18. Was Decedent Ever in the Armed Forces?  19. Was Decedent Ever in the Armed Forces?  19. Was Decedent Ever in the Armed Forces?  10. Was Decedent Ever in the Armed Forces?  10. Was Decedent Ever in the Armed Forces?  10. Was Decedent Ever in the Armed Forces?  11. Was Decedent Ever in the Armed Forces?  12. Was Decedent Ever in the Armed Forces?	_	Was Decedent of H If Yes, specify Cuba  1 Yes 2 No	lispanic Origin? (Sp	pecify Yes or No- Pican, etc.)	14. Race - A Black, V Specify:	American Indian, Vhite, etc.	
20	72 hou	ted	15. Decedent's Education (Specify only highest grade completed)	16a. Dece	dent's Usual Occup	ation	king	16b. Kind of Busine		
21215-0036	within ene. than "	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	life.	DO NOT use retired	d)	Wing			
	filed v Hygie othar t		10 17. Father's Name (First, Middle, Last)	⊥ CARP	ENTER	18. Mother's Nam	e (First, Middle,		RUCTION	
Maryland	should be nd Mental marked c	To Be	CHARLES SPEAL  19a. Informant's Name/Relationship (Type, Print)	10h Maili	an Address (Street		INE KOLL		7- O-d-	
S	and 2 si salth an n 27 is r		KITTY SPEAL WIFE		ng Address (Street					
Baltimore,	es 1 an of Heal fitam 2 r othar		20a. Method of Disposition 1 XX Murial 2 □ Cremation 3 □ Removal from State	Place of Dispo	osition (Name of matory or other place	1		20c. Location - City		
<u>Ē</u>	Pages tment of tant: If it		'4 □Donation 5 □ Other (Specify) GL	EN HAV	EN CEMETE	RY 4.2	2.2005	GLEN BU	RNIE, MD	
Ba	permil Depar Impor any in		21. Signature of Funeral Service License	18 F	2. Name and Addre	AL HOME,	P.A.			
			23a. Part1. Inter the disease) or complications that caused the dea shock, o heart failure—ist only one cause on each line.		26 CRAIN ter the mode of dyin	HWY SW GI ig, such as cardiac	or respiratory arr	L <b>E, MV210</b> est,	Approximate	
÷	Physician		Immediate Cause (Final disease or condition	cdia		tarchi			Interval Between Onset and Death	
	/Medical Examiner		resulting in death)  Due to (or as a conse		110000					
		er	Sequentially list conditions, b. Due to (or as a conse	quence of						
	cuted nd ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.							
8760,	ate be executed obysician and the burial-transit		resulting in death) Last Due to (or as a conse	quence of):						
687	icate t physics the b	edical	d						1	
P.O. Box (	The law requires that the death certificate be executed to has been signed by the attending physician and oage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of pregrant 1 □ Live birth 2 □ Fet 4 □ Pregnant at time of 9 □ Unknown			23d. Date of Month	delivery Day Year			
	w requires that been signed b should be deta	by	Part II. Other significant conditions contributing to death but not re	sulting in the u	inderlying cause give	en in Part I.			e to the cause of death?  Probably 4 Dunknown	
Vital Records,		Completed					24a. Was a autops perform	y prior	autopsy findings available to completion of cause of 1?	
Vita Vita	ticlan: Th certificate rector, pag	Be	25. Was case referred to medical examiner?		Othe	26. Place of Deat				
	F = E	. To	1 ☐ Yes 2 ☐ Mo	ER/Outpatier 28b. Time o	NE SUPPON	4   Nursing Ho		ence 6 Other (S	Specify)	
ion	Attanding Physician: or death. sector: After this certification in the funeral director, is	atlor	2 Accident investigation	Injury		k? Yes 2 □ No				
Division of	Hospital or Attano 24 hours after death Funaral Diractor: tely filled in by the	ertification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At i building, etc. (Special Could not be determined 28e. Place of Injury - At i building, etc. (Special Could not be determined 28e. Place of Injury - At i	nome, farm, str ify)	reet, factory, office		28f. Location (St City or Town	reet and Number or n, State)	Rural Route Number,	
	To the Hospital or Attanding within 24 hours after death.  To the Funaral Director: After completely filled in by the fune.	edical C	29a. Certifier (Check only one) 1 Gertifying Physician: To the best of my kn 2 Medical Examinar: On the basis of examinand manner stated.	owledge, death ation and/or in	h occurred at the time time time.	ne, date and place, pinion, death occur	and due to the cared at the time, da	ause(s) and manner ate and place, and o	as stated. due to the cause(s)	
•	To the within 2 To the complet	Me	29b. Sign ture and title disertifier	MI)	29c. License			9d. Date signed (Mo		
	D		30. Name and address of person who completed cause of death (Ite	m 23a) (Type,	Print) rans Hall	u Mi	Versu	le M	2005	
	Sta		31. Date filed (Month, Day, Year) 22. Registrar's Sign	ature	the -	)				
ĺ.	Registr	ar	APR 2 5 2005 Blacker A	The same of						

amend item#1, perfil , G842, 4/25/05 III State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Rag. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Martelban W Speaks III MARTALBAN Year **Physician** 1244 AM APRIL 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE, University Hospital If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 9. Birthplace (State or Foreign Country) MD 8. Date of Birth (Month, Day, Year) 1**X**M 2□ F Months Days Hours Min. 46 03-06-1959 212-74-3607 Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD NA Baltimore 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 629 North Paca Street 21201 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 X Never Married 2 ☐ Married 1 ☐ Yes 2√ No Specify: 3 Widowed 4 Divorced Specify: Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th grade Disabled na Disabled 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 Marvin Speaks Constance Wilson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4001 Clarks Lane, Apt 410, Louise Carlyle-Anut Balto, Md 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State □Donation 5 □ Other (Specify) Metro Crematory Inc. 4/20/05 Baltimore, Md 21 Signature of Funeral Savine Licensee 22. Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore, Md, 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final TRASIS disease or condition resulting in death) 10 days Due to (or as a consequence of): perbration duodenal Sequentially list conditions, if any, leading to immediate cause. Exist of confine Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of ULCER duodenal Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown

Physician /Medical Examiner

use as the burial-transit

Completed by Physician/Medical

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Certification; To

Medical

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29a. Certifier

attending physician and

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To the Funeral Director: After th completely filled in by the funeral

death.

after death

within 24 hours a

To the

or Attanding Phyaician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760.

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permit. Page Department i Important: ff any injury or

**Funeral** 

Director

Show

itam 27 is marked othar than "natural", or Items 23a or 28a-f shor othar traumatic evant, the Myoleal Examinata wat be molifled at

Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. int: If item 27 is marked other than "natural", or Ite

Maryland 21215-0036

Baltimore,

death with the Maryland

Examine

23e. Did tobacco use contribute to the cause of death?

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

HTN, DMII, PUD, hlo prior GIB, HIV, HCV

24a. Was an

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

yes Yes	formed?	
Check onl	one	

25. Was case referred to medical examiner?			26. Place of Dea	th Check onl one
1XYes 2□ No	Hospital:	ER/Outpatient	3 □ DOA Other: 4 □ Nursing H	ome 5 Residence 6 Other (Specify)
27. Manner of Death  1 Natural 5 Pending investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?  M 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred

investigation 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 - Homicide

and manner stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State) Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of ce

29c. License number 29d. Date signed (Month, Day, Year)

RES-ØØØØ

4/14/2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MALIK JACKSON, M.D. 22 South Green St., Balto, Md

31. Date filed (Month, Day, Year)

State Registrar

APR 2 5 2005



State of Maryland / Department of Health and Mental Hygien For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year AM ALEXAN DER SPENCER /Medical 2005 APRIL 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Northwest Hospital Randallstown Baltimore If Under 1 Year If Under 24 Hrs. | Months Days Hours Min. 5. Social Security Number **Funeral** 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 02 03 21 Birthplace (State or Foreign Country)
 VA 1 XM 2□ F Director Yrs. 230-01-9453 84 Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 28e-1 show 10d. Inside City Limits other traumatic event, the Medical Examiner wast be rectified at Director 1X Yes 2 □ No MD NA Baltimore 10e. Street and Number 10f Zip Code 10g. Citizen of What Country? with Items 23a 2503 North Rosedale Street 21216 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours atter c Department of Health and Mental Hygiene. Inportent: If item 27 is marked other than "neturel', or Item any injury or other traumatic event. The Medical Examinations. Black, White, etc. 1 Never Married XX Married 1 ☐ Yes 2X No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 þ 1 ☐ Yes 2 ☐ No Specify 3 ☐ Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 10th grade Machine Operator Lever Brothers Co. na 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Sam Spencer Mary Elvira ဂ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Helen Spencer-Wife 2503 North Rosedale St., Balto, Md 21216 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State ' 4 ☐ Donation 5 ☐ Other (Specify)

21. Si trature of Funeral Service Licensee 4/26/05 Md National Laurel, Md 22. Name and Address of Facility
March F/H West 4300 Wabash Ave, Baltimore, Md 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear fature. List only one cause on each line. Approximate Interval Batween Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician HCUTE /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any keap 12 immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last YER KALE MILE Physiclan/Medical Examiner Hospitel or Attending Physicien: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): physician s the burial Box 68760, as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death in the past 12 months? 3 Ectopic pregnancy Month Day 4 ☐ Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23a. Did tobacco use contribute to the cause of death? Division of Vital Records, λq director, page 2 should Completed 1 ☐ Yes 2 ☐ No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? 25 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 1 N Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? After 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending after death. investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 15 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) within 2 To the the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 2 D 41410. APRIL 215T, 2015. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOBINDER P MEHTA 31. Date filed (Month, Day, Year) HUSPITAL CENTER RANDAUSTOWN MO 22. Registrar's Signature State Registrar APR 2 5 2005

			For State Registrar	State of Ma	ryland / Depa	artment of Hertificate of L			ene 2005	13890
			1. Decedent's Name (First, Middle, La	ast)				2. Date of Death		3. Time of Death
	Physici: /Medic Examin	al	Thomas  4a. Facility Name (If not institution, gir	Joseph		Schuss1		Month APRIL 21	Day Year  2005  4c. County of Dea	08:15 P M
	LXdiiiii	٠,	SAINT JOSEPH MEI	TCAT CENTE	D					
	Funeral		5. Social Security Number 6.	Sex 7. Age	(In yrs. last birthday)	TOWSO	If Under 24 Hrs.	8. Date of Birth	BALTI 9. Bird	hplace (State or Foreign
	Director		217-46-0319	1 M 2 F	57 Yrs.	Months Days	Hours Min.	(Month, Day, ) Feb. 6 1		yland
	pu ,		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo					
	ehov	'n	Maryland Baltimo	re	Owings Mi					10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	he M	Director		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	OWINGS III			1		
	with t	늡	10e. Street and Number			10f. Zip Code		100	g. Citizen of What Co	
	eath	Funerai	4 Oakmere Road	12. Was Decedent E	war in II 6	21117	io Osiaio 2 (Ca	anifu Van au Na	U.S	
	iter d	S	1 Never Married 2 Married	Armed Forces?		Was Decedent of His If Yes, specify Cubar	n, Mexican, Puerto	Rican, etc.)	Black, Whit	
920	urs ar	þ	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1□Yes 2√⊋No	Specify:		Specify: Wh	ite
Ą	within 72 hours after death with the Maryland ene. than "naturel", or items 23e or 28a-f ehow he Medical Examinan must be recified at	Completed	15. Decedent's E	ducation		dent's Usual Occupa		. 16	l 3b. Kind of Business/	Industry
215	hin 7	ple	(Specify only highest gr Elementary/Secondary (0-12)	ade completed) College (1-4or 5-	life	kind of work done d DO NOT use retired)	uring most of work	ing		
2	od wil	Con	12	NA		Manager			Electrica	l Warehouse
nd	be filled tal Hygi d other event, I	Be (	17. Father's Name (First, Middle, Last	")			18. Mother's Name	e (First, Middle, Ma	niden Surname)	
yla	2 should be filed within 72 hours after death with the Marylan and Mental Hygiene. Is marked other than "naturel", or items 23e or 28a-1 ehow eumatic event, the Medical Exantic crimit be political.	2		seph	Schussl	er Sr.	Dorothy	7	Caple	
Nar	2 sh and is m		19a. Informant's Name/Relationship			-			City or Town, State, 2	'
6	es 1 and 2 of Health a litem 27 is r other tre		Judith Schussler	(Wife)					Maryland	
lor	in ite		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐		20b. Place of Dispo cemetery, cres		)   Apri	26, 26	c. Location - City or	Town, State
Baltimore, Maryland 21215-0036	it. Parturent		* 4 ☐ Donation 5 ☐ Other (Special Service Lies		Gardens o		2005	3	altimore,	Maryland
Ba	permit. Pages 1 and 2 should be Department of Health and Menta Importent: If item 27 is marked any injury or other treumatic evenes.		21. Signature of Funeral Service Lice		. /	Name and Address W. Dabro	s of Facility wski/Choj	jnacki Fu	neral Hom	es P.A.
			23a Part1. Forer the disease or com	unlications hat caused	the death. Do not ent	1005 Dund	alk Ave.	Baltimor	e, Maryla	nd 21224 Approximate
			23a. Part1. Enfer the disease, or comshock, or heart failure. List only Immediate Cause (Final	one cause on each line	e.	er the mode or dying	, such as cardiac c	n respiratory arres	,	Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)		TEM ORGAN	FAILURE				
Ĭ.	Examiner		- 1		consequence of):					
		er	Sequentially list conditions, if any, roading to initiralizate cause. Enter Underlying	b. SEPTIC S	echequeries of:			-		
	d d ansit	Examiner	Cause (Disease or injury that initiated events	TESTICUL	AR SEMINOM	IA				
o,	icate be executed physician and s the burial-transit	Ex	resulting in death) Last	Due to (or as a	consequence of):					
8760,	ate be nysici he bu	dicai	•	_ d						
9	artifica ing pl e as t	Med	IF FEMALE:							
Вох	eath certific attending p	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 ☐ Live birth 2	Fetal death 3	Ectopic pregnancy			23d. Date of deli Month	
o.	at the dea by the a tached f	Physician/Me	1 Yes 2 No	4□Pregnant at t 9□ Unknown	ime of death 5	Other (specify)			WOTH	Day Year
<u>α</u>	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Ph	Part II. Other significant conditions	contributing to death but	t not resulting in the u	nderlying cause give	n in Part I	23e Did toba	cco use contribute to	the cause of death?
Records,	ires tha signed d be del	Ō	NEUTROPENIA	,		radifying adda given	THIT CALL.	1 ☐ Yes	2 No 3 □ Pro	
Ö	w requir been si should	ete	MIOTROI BIVITI							
Rec	has has	Completed						24a. Was an autopsy	prior to c	topsy findings available completion of cause of
	n: Th ficate or, pa		GE Was some referred to medical					performe 1  Yes 2	No 1 ☐ Yes	2 No
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Division of	y Phy er this eral d	n; To	27. Manner of Death	28a. Date of Injury	28b. Time of	28c. Injury	at at	28d. Describe how	e 6 Other (Specinjury occurred	ery)
o	nding th.: Afte	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investigatio	(Month, Day	Year) Injury	M 1 TY	? es 2 □ No			
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Ō	s after s after of Direct	Certification;	4 🗆 Homicida	building, etc.	(Specify)			City or Town, S	orare)	
	To the Hospitel or Attending Physicien: The twithin 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page		29a. Certifier 1 Certifying Pt	nysician: To the best of miner: On the basis of e	my knowledge, death	occurred at the time	e, date and place, a	and due to the caus	se(s) and manner as	stated.
	the H in 24 the F iplete	Medicai	0170	and manner state	ed.	restigation, in my opi	nion, death occurr	ed at the time, date	and place, and due	to the cause(s)
	To To	2	29b. Signature and title of certifier	1 P.	hi	29c. License	number	29d	Date signed (Month	, Day, Year)
1	4		· the	4 100	0,111,	D 2403	4		4/4/1	25
6	`		30. Name and address of person who						1	
$\leq$			TIMOTHY LOW, M.I. 31. Date filed (Month, Par, Year)	0., 7601 OS 32. Belistrar	LER DRIVE	TOWSON, M	ARYLAND	21204		
	Stat			, ou impulation						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. C. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Year 5-30 PM JUSTINE CAROLYN TAYLOR APRIL /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Agnes Health Care, 900, Caton Ave Baltimore NA If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months, Day, Year) (2 - 24 - 1943) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🗷 F 212.42.7166 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Director BALTIMORE 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? CIRCLE 21227 2938 LAKEBROOK USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. uges 1 and 2 should be filed within 72 hours after d it of Healin and Mental Hygiene.
If itam 27 is marked othar than "natural", or item or othar traumatic evant, it is Medical Examination 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Tes 2 No ģ Specify: BLACK 3 ☑ Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+)
N A 12/1H GRADE AIDE DAVCARE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ROBERT BROWN, JR JOSEPHINE DORA FORD 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5109 QUEENSBERRY AVE. BALTO. MD. 21215
ace of Disposition (Name of Date 20c. Location - City or Tov JAMES TAYLOR & ROBBIN TAYLOR 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 K Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: If any injury or once. \*4 □Donation 5 □Other (Specify) 04.26.05 BALTO. MD ARBUTUS 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
YAUGHN C. GREENE FUNERAL SERVICE Vangs 5151 BALTO. NATE PIKE, BALTO. MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Physician 2 days /Medical **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physiclan/Medical Examiner Due to (or as a consequence of) Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year 4☐Pregnant at time of death Day 5 ☐ Other (specify) P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Hypertension 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖼 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed2 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Unpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Certification: To 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation after death 6 Could not be determined 3 🗋 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide within 24 hours a To tha Funaral L McCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartifier Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 10

JUSTINE

AYLOR

31. Date filed (Month, Day, Year) State Registrar

Dr. Anitha Nally

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) St-Agnes Health Case, 900, Caton Ave, Baltimore, 40-21228. 32. Registrar's Signature Bearin & Aparle

DHMH 17 Rev 1/2001

05-2794

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			Registrar  1. Decedent's Name (First, Middle, Las		Tillicate of Death	Reg.	No. C U U O	3. Time of Death					
	Physici		CHRISTING	A	THOMAS		Day 2005	1:13 <sub>p</sub> M					
	/Medi Examir		4a. Fecility Name (If not institution, give JOHNS HOPKINS HOS	street and number)	4b. City, Town, or Location of Deat BALTIMORE CITY		4c. County of Death	<b>-чэ</b> р					
	Funeral Director		5. Social Security Number 6. Security Number 6. Security Number 11 Usuel Residence of Decedent	9X ☐ M 2 ☐ F 7. Age (In yrs. last birthday ☐ Yrs.	If Under 1 Year   If Under 24 Hrs   Months   Days   Hours   Min.	8. Date of Birth (Month, Day, Ye AUG - 24	9 Birthole	ece (State or Foreign ny) H CAROLIA					
	yland yland		10a. State 10b. County	10c. City, Town or L	ocation		10	d. Inside City Limits					
	death with the Maryland me 23a or 28a-f show froust be nutified at	Director	MARYLAND N.	IA	BALTIMORE 101. Zip Code	C1 TY	Citizen of What Count	1 X Yes 2 □ No					
	23a or	i Di	1719 NORTH	MONTFORD AVE	2.121	3	USA.	. y :					
36	or Ite	by Funeral	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever in U.S. Armed Forces?  1  Yes 2 No If Yes, Give	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer 1 Yes 22 No Specify:	pecify Yes or No- o Rican, etc.)	14. Race - America Black, White, e						
5-0036		ed b	3 ☐ Widowed 4 ⚠ Divorced  15. Decedent's Ed	Year or Dates:	dent's Usual Occupation	166	. Kind of Business/Indu	ACK.					
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	e filed other vent, II	a l	17. Father's Name (First, Middle, Last)	2423 1200	1CATON ASSIS 18. Mother's Nar	ne (First, Middle, Maid	ALTIMORE Ien Sumame)	20179					
ylar	2 shoutd be and Mental is marked of aumatic eve	To B	TOM	EMANG	IEL VIOI	JETTE	MI	LES					
Maryland	2 sho	6	19a. Informant's Name/Relationship (7		ing Address (Street and Number or Ru	F-100-							
	Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. Init: If item 27 is marked other than iry or other traumatic event, It a M		20a. Method of Disposition  1 Burial 2 Cremation 3	Removal from State	osition (Name of matory or other place)	Date 20c.	Location - City or Tow	n, State					
Baltimore,	permit. Pag Department Important: any injury conce.		21. Signature of Funeral Service Licensee  22. Name and Address of Fully BROWN TR. FUNERAL  22. Name and Address of Fully BROWN TR. FUNERAL  24. Dietuch N. Williams 3746 N. FULTON AVE. BALTO, MD										
			23a, Part1. Enter the disease, or comp	lications that caused the death. Do not en	2/40 No F-ULT	ON AVE.		D 2/2/1					
4	Pnysician		shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death)	one cause on each line.  a. ARTERIOSCLEROTIC (				nterval Between Onset and Death					
	/Medical Examiner		resulting in death)	Due to (or as a consequence of):									
		ner	Sequentially list conditions,	b. — Due to (or as a consequence or):									
	ecuted and transi	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										
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687	ifficate g phys	edical		d									
O. Box	es that the death certificate be executed igned by the attending physician and be detached for use as the buriat-transit	Physiclan/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month D	ay Year					
P.O	law requires that the as been signed by th 2 should be detache	by Ph		ntributing to death but not resulting in the u	nderlying cause given in Part I.	23e. Did tobacc	o use contribute to the	cause of death?					
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eco	law re nas ben s 2 sho	Completed				24a. Was an autopsy	24b. Were autops	y findings available of					
al R	: The lav					performed? 1 ☐ Yes 2 🔯 1	death?						
Vita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:	O+	th Check onl one)							
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	To the comp	Ĭ	29b. Signature and title of certifier		29c. License number		Date signed (Month, Da						
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1	)			ompleted cause of death (Item 23a) (Type,	111 Penn Str	eet Baltir	more, Maryl	and 21201					
	Sta Registr	16	31. Date filed (Month, Day, Year)  APR 2 5 2005	32. Registrar's Signature									

			and the state of t	ertment of Health and Mertificate of Death	, ,	ene	
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	/Medi Examir		CORNELIUS TILLMAN  4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	April	22 2005 8 45 A 4c. County of Death	М
	LXaiiiii	ici	Sinai Haspital	Baltimore,		40. County of Death	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday		8. Date of Birth (Month, Day, Y	9. Birthplace (State or Foreign Country)	gn
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	d within 72 hours after death with the Maryland giene. The Modical Evantrals 23a or 28a-f show The Modical Evantral must be ricillised at	Funerai Director	3302 INGLESIDE AVENUE	21215		USA	
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-003	hours after tural', or ita	by	1 ☐ Never Married 2 ☐ Married 1 ☐ Wes 2 ☐ No If Yes, Give Year or Dates:	1 ☐ Yes 2X No Specify:		Specify: BLACK	
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ana		Be	THOMAS TILLMAN	18. Mother's Name	(First, Middle, Ma.  . KESS	iden Surname)	
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e, G	es 1 and of Health of Health fitem 27 r other tr		20a. Method of Disposition 1 □XBurial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition	osition (Name of Damatory or other place)	ate 20	c. Location - City or Town, State	
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	nysician /Medical Examiner		23a. Paper. Enter the disease, or complications that caused the death. Do not ensheck, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence of):	Adenocarcine		Interval Between Onset and Death 4 month	S
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חשבו ו	To the Hospital or Attending Physician: The law requires that the death certification 24 hours after death.  Anthin 24 hours after death.  To the Funeral Director. After this certificete has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Completed	history of urosepsis	/ /	24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death?	Э
V   [a	sician certifi rector	o Be	25. Was case referred to medical examiner?  Hospital: M. Hospital:	26. Place of Death			
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	Tot	Σ	29b. Signature and title of certifier.	29c. License number	29d.	Date signed (Month, Day, Year)	_
			Tu McIntiRE		o A	pril 22, 2005	
,	141		30. Name and address of person who completed cause of death (Item 23a) (Type,	Print)		pril 22, 2005 BALTIMORE	
	Sta	te	31. Date filed (Month, Day, Year)  32. Register's Signature  ADR 2 5 2005	SINAL HOSPITA	COTI	3HCI IMORE	
	Registr		APR 2 5 2005	5			

			For State Registrar	State of Maryland / Department of Health and Mental Hygiene   1 5   3 8 9 Certificate of Death								13894			
	Physici	an	1. Decedent's Name (First, Mic	idle, Last)	i i					2. Date of De Month		Day Year		3. Time of Death	
	/Medic		John	7.		vombea					April	20	), 20	05	5:30P.M.
	Examir	er	4a. Facility Name (If not institu			r)		ity, Town, o					County of		nde1
	Funeral		5. Social Security Number	6. Sex	7. A	ige (In yrs. last birth	Mon	everna nder 1 Year hs Days	If Under	24 Hrs. Min.	8. Date of Bir (Month, Da	th Year)	9		lace (State or Foreign
	Director		213-34-0235 Usual Residence of Decedent	1 Z M	207	67 Y	rs.				Sept.	21,	1937	Mar	yland
	land ow		10a. State 10b. Cour	nty		10c. City, Town	or Location							1	0d. Inside City Limits
	Man B-feh	tor	Maryland Ann	e Aruno	le1	Miller	sville	۲							1 ∐Yes 2 PMo
	or 28	Director	10e. Street and Number		10f. Zip Code 10g. Citizen of W							izen of Wh	at Coun	try?	
	ath w		818 Oakdale C					211	08				U.S.	Α.	
	er de Items	Funeral	11. Marital Status	. A	med Forces		13. Was De If Yes,	specify Cuba	ispanic Orig an, Mexican	gin? (Spe i, Puerto	ecify Yes or No Rican, etc.)	-	<ol> <li>Race - Black,</li> </ol>	Americ White,	
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	alth a		Ann Thompson	(Wife)		,									d 21108
altimore,	iges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygiene.  If the file is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be rediffed at		20a. Method of Disposition  1 Burial 2 Cremation			20b. Place of I	Disposition (	Name of		0	ate	20c. Lo	cation - Cit	ty or To	wn, State
Ĕ	Page ment ant: h		`4 □ Donation 5 □ Other		vai from Stati	Meadow	ridge	Mem. 1	Pk.	4/23	/05	E1kr	idee.	Mar	ryland
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	cale be executed  //Medical  Examiner  the purial-transit  the purial-transit		snock, or near failure. L	se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line.								Approximate Interval Between Onset and Death			
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8760,			resulting in death) tast	Due to (or as a consequence of):								Alex			
	physics the l	d. Neutropenia										490			
Box 6	death certific e attending p nd for use as	Physician/Me	IF FEMALE: 23c. If yes, outcome of pregnancy										23d. Date of delivery		v
Ď.	death e atte d for	iciai	in the past 12 months?	in the past 12 months?  1 Yes 2 No.  4 Pregnant at time of death 5					3 □Ectopic pregnancy 5 □ Other (specify)					Month Day Year	
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Vital Records, P	Se 100	by	Part II. Other significant cond	tions contribu	ting to death	but not resulting in t	he underlyin	g cause give	en in Part I.			bacco u 'es 2[		ite to the	e cause of death?
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	iysician: Th		25. Was case referred to medi examiner?						26. Place	of Death	(Check only o				
0	g s		1 ☐ Yes 2 No	Hospit	1 U Inpat			DOA Othe	XINUI	_	ne 5 Resid			Specify,	)
			27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined 4 Underside State of Injury - At home, farm, street, factory, office 28a. Date of Injury 28b. Time of Injury at Work? M 1 Yes 2 No 28b. Place of Injury - At home, farm, street, factory, office 28b. Location (Street and No.								28d. Describe h	d. Describe how injury occurred			
DIVISION	or Attending after death. Director: After in by the fune										d Number o	or Rural	Route Number		
5	in the contract of	Serti	4 Homicide	11111100	building, e	tc. (Specify)	., ,	,			City or Tow	n, State,		, , , , ,	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
	vithin 24 hours after of To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	Medical C	29a. Certifier 1 Certifier (Check only one) 2 Medic	ai examiner: (	n: To the besi On the basis and manner s	t of my knowledge, of examination and/ tated.	death occurr or investigat	ed at the timion, in my or	e, date and pinion, deat	d place, a h occurre	and due to the coded at the time, co	ause(s) date and	and manne place, and	er as sta	ited. the cause(s)
	withii To the Comp	Σ	29b. Signature and title of certing	ا الم				29c. License	number		4	29d. Date	e signed (A	Aonth, D	Pay, Year)
	- 1					1 hysicia	N	Doo!	5695	0		Ap	n'l Z	1, 2	005
ibX	19		30. Name and address of perso	h who comple		th (I m 23a) (T	ype, Print)	)	0.	5 (	2.54 A	0.	.1.		W 21122
	Sta	0	Nnaemeka 31. Date filed (Month, Day, Yea	(r) U		8094 Ed	WIN	raymo	v 151W	40 g	MIR H	ra	a oen	4 N	W 21122
	Registr		APR 2		1	16	Annal's	,							

DHMH 17 Rev 1/2001

			State of Maryland / Department of Health and Certificate of Death	d Mental Hy	rgiene	12005							
			Decedent's Name (First, Middle, Last)		2. Dete of Deeth 3. Time of Death								
	Physicia /Medic		MARY VINCENT	Month 04	05 2005								
	Examin	er	4e Fecility Neme (If not institution, give street end number)	or Location of Deel	1 - 1	n DEE							
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) If Under 1 Year If Under 24 h	HIM ORS									
н	Director		235-38-5931 1□ M 2\(\textbf{X}\)F 98 Yrs. Months Deys Hours M	lin. 8. Dete of Bi (Month, Di Mar 9,	1907 Wes	rthplece (State or Foreign ountry) st Virginia							
	pi .		Usuel Residence of Decedent  10a. Stete 10b. County 10c. City, Town or Location		10d. Inside City Limits								
	sho	5		1 □ Yes 2 ▼ No									
	the N	ect	10e. Street end Number 10f. Zip Code		10g. Citizen of What C	ountry?							
21215-0036	h with	in in	1046 Old North Point Road 21224	USA									
	d 2 should be filed within 72 hours efter death with the Marylend thend Mentel Hygiene. 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Madical Examiner must be notified at	by Funeral Director	If Yes, Give Year or Dates:	(Specify Yes or No lerto Rican, etc.)	o- 14. Race - Am Black, Whi Specify: W	ite, etc.							
5-0	72 ho	3	15. Decedent's Education (Specify only highest grade completed)  16e. Decedent's Usual Occupation (Give kind of work done during most of life. DO NOT use retired)	working	16b. Kind of Business	s/Industry							
21	ithin i	Completed	Elementery/Secondary (0-12) College (1-4or 5+)  Leacher  College (1-4or 5+)  Leacher	WO KING									
121	filed with Hygiene. Ither ther	S	12 4 teacher	Name /First Middle	educat: , Maiden Sumame)	ion							
and	ould be fi Mentel H erked off	ă	Flored D 11 D. L.	Hester D									
Maryland	should to end Ment is marked	2	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or			Zip Code)							
	end 2 saalth er n 27 is er trau	1	Richard Vincent/son 1 Yorkship Square D		•	,							
Baltimore,	eges 1 ant of He it: If Item y or oth		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  4 ☒ Donation 5 ☐ Other (Specify)	Date	20c. Location - City or	r Town, State							
Balti	permit. Pe Depertmen Important: any injury once.		21. Signature of Euneral Service Licensee Ronald S. Wade, Virector State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201										
			23a Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock or heart failure. List only one ceuse on each line.  Approximete Interval Between										
	Physician /Medical Examiner		Immediate Ceuse (Final disease or condition  a. DIABETES MELLI-	505		Onset and Death							
		ē	Due to (or as e consequence of):			1							
	outed id ensit	Examiner	Sequentially list conditions  Due to (or as a consequence of):										
o,	ificate be executed g physicien end as the buriel-trensit		Ceuse (Disease or injury that initieted events greathing in death) and the control of the contro										
68760,	hysici the bi	edicai											
	= D 0												
Вох	eeth certifi ettending for use es	cian				L							
P.O.	y the	Physician/M	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.			e to the cause of death? Probably 4 Dunknown							
	s thet ned b e dete	by P		'	765 20 NO 30 F	Tobably 4 Donkhown							
of Vital Records,	The law requires thet the deeth cert ise has been signed by the ettending page 2 should be deteched for use	Completed		24a. Wes	s en autopsy 24b. ormed?	Were autopsy findings available prior to completion of cause of death?							
Ä	The law te has bege 2	E		13	Yes 21 No	1 □ Yes 2 □ No							
'ita		-	25. Was case referred to medical 26. Place of Javannian 26. Place of Javannian 27.	Death (Check only	one)								
of V	S 50	은	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Virginia		idence 6 Other (Spe	ecify)							
	Ing P	0	27. Menner of Deeth 1 Deature   5 Pending (Month, Day Year)   28b. Time of Injury   28c. Injury at Work?	28d. Describe	how injury occurred								
Division	To the Hospital or Attending Ph within 24 hours efter deeth. To the Funeral Director: After th completely filled in by the funeral	Certification:	2 Accident investigetion 3 Suicide 4 Homicide investigetion 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)								
_	To the Hospital within 24 hours of To the Funeral Completely filled	edical C	29a. Certifier  (Check only onl)  (Check only onl)  (Check only onl)  (Check only onl)  (Check only onl)  (Check only onl)  (Check only onl)  (Check only onl)  (Check only onl)  (Check only onl)  (Check only onl)  (Check only onl)  (Check only onl)  (Check only onl)  (Check only onl)										
	Withir To th		29b. Signature and title of certifier 29c. License number	29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)									
			Sander [ Tulle MD D27/8	28	4/18	105							
7			30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print)	1									
-			Spinder Coulle 2 Market Va	ce Di	entalk o	40 21 222							
	Stat Registra	•	APR 2 5 2005										

DHMH 16 Rev 6/95

**ORIGINAL** 

		•		e of Maryland / Do		ealth and Me	-		396		
	Physicia /Medic		Decedent's Name (First, Middle, Last)     WILLIAM MCKINLEY		2.	Day Year 3. Time of Death 20 2005 12:00 PM					
	Examin							4c. County of Death Baltimore			
	Funeral Director		212–18–9497	7. Age (th yrs. last birth	Months Days		Date of Birth (Month, Day, Yea 1-27-191	9 Birtholace (State of	or Foreian		
	ith the Maryland or 28a-f show	tor	Usual Residence of Decedent  10a. State 10b. County  MD BALTTMORE	10c. City, Town		ROSEDALE		10d. Inside C 1 ☐ Yes	ity Limits		
am	with the 3a or 28a	I Director	10e. Street and Number 8008 CARADOC DRIVE		10f. Zip Code	21237	10g. (	Citizen of What Country?			
	iit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland enfinent of Health and Mental Hygiene. orient: if item 27 is marked other than "natural; or fams 23s or 28s-f show njury or other traumatic event. I'm Medical Examinatin that be multiled at it.	by Funeral	1 Never Married 2 Married	Decedent Ever in U.S. ed Forces? Yes 2 No s, Give or Dates: WWII	13. Was Decedent of His If Yes, specify Cubar	spanic Origin? (Specif , Mexican, Puerto Ric Specify:	y Yes or No- an, etc.)	14. Race - American Indian, Black, White, etc.  Specify: WHITE			
ال 1215-0036	within 72 horene. ene. than "natura	Completed	15. Decedent's Education (Specify only highest grade comple Elementary/Secondary (0-12) Colle	sted) 16a. [ (ge (1-4or 5+)	Decedent's Usual Occupa Give kind of work done di life. DO NOT use retired) ENGINEER	tion uring most of working		Kind of Business/Industry			
S , land 21	2 should be filed with and Mental Hygiene. Is marked othar that aumatic evant. Itum	To Be Cor	10 17. Father's Name (First, Middle, Last) EDWIN D. WALTERS			18. Mother's Name (F		AIL ROAD on Sumame)			
ドers, Maryland	nd 2 should aith and Men 27 is marke ir traumatic		19a. Informant's Name/Relationship (Type, Print JOY GIORDANO/ DAUGHT	,	Mailing Address (Street a. KRISTAL CO		oute Number, Cit IMORE, M	y or Town, State, Zip Code) D 21236			
$ U_{\mathcal{O}_{\mathcal{K}}} $ Baltimore,	permit. Pages 1 and Department of Health Importent: If itam 27 any n]ury or other tr 9005.		20a. Method of Disposition  1 □ Burial 2 □ Cremation 3 □ Removal  4 □ Donation 5 ▼ Other (Specify) ENION	from State cemetery,	Disposition (Name of crematory or other place)			Location - City or Town, State  ALTIMORE, MD			
// Balti	permit. Depertm Importe any nju		21. Signature of Funeral Source Leensee				H/ROSEDA	LE FUNERAL HOME	) ;		
•	Physician /Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Approximate Interval Between Onset and Death  Due to (or as a consequence of):  Seguentially list conditions,								
68760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  d.								
P.O. Box 6	the death certificate by the attending physic ched for use as the b	Physician/Med	in the past 12 months?	s, outcome of pregnancy Live birth 2 □ Fetal death Pregnant at time of death Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			23d. Date of delivery Month Day	Year		
	uires that the dei signed by the a lid be detached fo	by	Part II. Other significant conditions contributing		cco use contribute to the cause of death? 2 1√No 3 □ Probably 4 □Unknown						
Division of Vital Records,		Completed					24a. Was an autopsy performed 1		available ause of		
Vita	sicien:	To Be	25. Was case referred to medical examiner?  1  Yes 2 No Hospital:	1 N patient 2 ER/Outp	patient 3 DOA Othe	26. Place of Death (C		6 ∏Other (Specify)			
ion of	nding Phy tth. :: After this e funeral c										
Divis	To the Hospital or Attanding Physicien: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, I	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)								
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical (	(Check only 2 Medical Examinar: On	o the best of my knowledge, the basis of examination and manner stated.	death occurred at the time for investigation, in my op	e, date and place, and inion, death occurred	I due to the cause at the time, date a	(s) and manner as stated. and place, and due to the cause(s	s)		
	To the To the Comp	Σ	29b. Signature and title of certifier		d. Date signed (Month, Day, Year)  1-20-2005						
	77		30. Name an address of person who completed Dr. Jason Birnbau	m 9000 Fr	Type Print)			more, MD212			
-	Sta Registr		31. Date filed (Month, Day, Year) APR 2 5 2005	33 Penietrar's Sinnature	Acerts.						

DHMH 17 Rev 1/2001

amend item#22, per in , 842, 4429/05 tt Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 9,50 P APRIL 18 2005 /Medical Kevin Timothy Ward 4a. Facility Name (If not institution, give street and number, 4b. City. Town, or Location of Death 4c. County of Death Examiner GOOD SAMARITAN BALTIMORE HOSPITAL If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth Month Day, Year) AUg 15, 1956 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 1 X M 2 □ F Maryland 48 556-92-8470 Director Usual Residence of Decedent 72 hours atter death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic evant, the Madical Examinar must be notified at MD 1 Yes 2 No Raltimore Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 211 Hollen Road 21212 or itams 23a USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ZNo If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Be Completed by Specify: white 3 ☐ Widowed 4 ☐ Divorced Year or Dates: "natural', 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) and Mental Hygiene. Ia marked othar than College (1-4or 5+) salesperson self employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be fill ment of Health and Mental Hisant: If itam 27 ia marked oft James J. R. Ward Nancy A. Lang 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Phyllis Ward/spouse 211 Hollen Road Baltimore, MD 21212 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ō Department of Important: If any injury or once. \* 4 X Donation 5 ☐ Other (Specify) 21. Signal in Funera Sivice Sicensee Wade Director Mitchell-Wiedefeld Funeral Hore, Inc. 21201 6500 York Rd. Baltimore, MD 21212 Baltimore, Mb Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, wheart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CARDIOMYOPATHY a END STAGE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underning Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy jo in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ 1 Yes 2 No 3 Probably 4 Onknown Be Completed IVER DISEASE 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 certificate has 1□ Yes 2□No director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No death investigation 2 Accident within 24 hours after deatl To the Suneral Director: 3 🗌 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) tilled in by 4 Homicide

b

To the Hospital

State Registrar

Medical

29a. Certifier (Check only one)

29b. Signature and title of certifier

61

31. Date filed (Month, Day, Year) APR 2 5 2005

BOURJEILY , 5601 LOCH RAVEN BLVD, BALTIMORE, MDZ1239 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6000 SAMARITAN

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

P15306

29d. Date signed (Month, Day, Year)

4118105

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	ckie M.	W	illiams	ricase	State of Ma								-	•		
		•	For State Registrar			,			tificate of			Reg. N	2000	1	3898	
)	Physici /Medio Examir	an al	4a. Facility Name (II	E M. WILL f not institution, give					4b. City, Town, o			17	2005 4c. County of De	6:	04 P M	
Ī	Funeral Director			0-7426 6. Se	Ax Age (In yrs. last birthday)  The state of the state of				n, 8. Date of B	lay, Yea	N/A 9. B 9. B 9. B MA					
	be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or tlems 23e or 28e-f show event, the Medical Examinar must be notified at	tor	Usual Residence of 10a. State MD •	10b. County N/A		10c. City,	Town						Year) Country) -1952 MARY LAND  10d. Inside City Limits 1 □ Yes 2 □ No			
		Funeral Director	10e. Street and Nur 4006	CRANSTON	RD.				10f. Zip Code 212.	29		10g. (	10g. Citizen of What Country?  USA			
036	ours after dea ral', or Items Eraminar m	by	a 3 ☐ Widowed 4 ☐ Divorced Year or Dates:							(Specify Yes or N arto Rican, etc.)	(es or No- , etc.)  14. Race · American Indian, Black, White, etc.  Specify: BLACK					
15-003	in 72 ho n "natur fedical	Completed		15. Decedent's Ed	de completed)		16a. [	Decede (Give k life. D	ent's Usual Occup kind of work done OO NOT use retired	nation during most of w	vorking	16b.	Kind of Busines	s/Industry		
212	filed with Hygiene. ther thai	Com	Elementary/Second		College (1-4or 5 -0-	(+)		DIS	SABLED				DISABIL	ITY		
Maryland		To Be		7. Father's Name (First, Middle, Last) FLOYD D. WILLIAMS							ame (First, Middle Z. E. HOR	-,	en Sumame)			
	h ar h ar 7 is trau	19a. Informant's Name/Relationship (Type, Print)  RUBY WILLIAMS (MOTHER)  19b. Mailing Address (Street and Information of CRANSTON Information Informa														
more,	Pages 1 and nent of Healt ant: if Item 2 ary or other				Removal from State	Cei	metery	, crem	sition (Name of natory or other place FOREST	' 1	Date 26-2005		Location - City o			

**Physician** /Medical

Examiner

Examiner Physiclan/Medical þ Completed Be Certification:

attending physician and for use as the burial-transit After this certifications funeral director, p

Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Complications Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown 1 🗌 Yes 24a. Was an 24b. Were autopsy findings available

21. Signature of Funeral Service Licensee JONATHAN D. HIBNER Name and Address of Facility PHILLIPS FUNERAL HOME, P.A.

						autopsy performed? death?  1 ☑ Yes 2 ☐ No 1 ☑ Yes 2 ☐ No
25. Was case referred to medical	de de			26	Place of De	eath (Check only one)
examiner? 1 XYes 2 □ No	Hospital: 1 Inpatient 2	ER/Outpatient	3□ DOA	Other:	□ Nursing	Home 5 ☐ Residence 6 Y Other (Specify) Scc ☐ C
27. Manner of Death 1 X Natural 5 ☐ Pending 2 ☐ Accident investigati	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c	. Injury at Work? 1 ☐ Yes	2 🗆 No	28d. Describe how injury occurred
3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		ome, farm, street,	factory, o	office		28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

**OCME** 

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ZGreenbe

111 Penn Street Baltimore, Maryland 21201

April 18 2005

State Registrar

Medical

31. Date filed (Month, Day, Year)

APR 2 5 2005



			For State Registrar	State of Ma	aryland /			nt of He te of D		Mental Hy	/gien Reg. N		
	Physici		Decedent's Name (First, Middle, Las Shirley	Ann	Anas	tasi				2. Date of D Month April	D	ay2 () Year 2005	3. Time of Death 6:30 p M
)	/Medic Examin		4a. Facility Name (If not institution, give 5 Brighton Lane						ocation of Dea	-		c. County of Death	<u> </u>
Ī	Funeral Director		Social Security Number 6. S	9x 7. Age □M 2【XF	68	virthday) Yrs.	If Und Months	or 1 Year Days	If Under 24 Hr Hours Mir		ay, Yea		place (State or Foreign intry) hington, DC
	Maryland f show	or	Usual Residence of Decedent  10a. State 10b. County  Maryland Mon-	tgomery	10c. City, To			sburg					10d. Inside City Lîmits 1 ☐ Yes 2 🛣 No
	n with the ? 3e or 28e-	al Director	10e. Street and Number  5 Brighton Lane				10f. Z	ip Code 2087	7		10g. C	itizen of What Cou US	•
36	2 should be filed within 72 hours after death with the Maryland and Mental Hyglene. Is marked other then "naturel", or Items 23e or 28e-f show eurnatic event, the Medical Exama har must be rediffed at	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent It Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:				edent of His ecify Cuban 2™ No		Specify Yes or N rto Rican, etc.)	0-	14. Race - Ameri Black, White, Specify: W]	
Maryland 21215-0036	within 72 hou ane. Ihen "nature	Completed	15. Decedent's Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5		(Give k life. D	ent's Us kind of w OO NDT		ion ring most of we	orking	16b.	Kind of Business/Ir	
land 2	illed Hygl other	ø	17. Father's Name (First, Middle, Last) Clinton Davis				memo			ame (First, Middle therine		n Sumame)	Onic
, Mary	and 2 shousaith and M n 27 is mai		19a. Informant's Name/Relationship (7			5 Br	ight	on La		thersbu	g,	or Town, State, Zij Maryland	20877
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Importent: if Item 27 is marked any injury or opper treumatic events.		20a. Method of Disposition  1 □ Burial 2 ♣ Cremation 3 □  '4 □ Donation 5 □ Other (Specify	)	20b. Place cemet	ery, crem olitar	atory or n Cre	other place, matory	Apr		Ale		own, State  Virginia
Ball	permit Depar Impor any in		21. Signature of Funeral Service Lices	Sofe	the death Do	5	00 U	niver	sity Bl	vd, W, S	Silv	ome Inc. er Spring	g, MD 20901
>	Physician /Medical		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  A Myocardial Infarction  Due to (or as a consequence of):										Interval Between Onset and Death
	Examiner	Examiner	Due to (or as a consequence of):  Coronary Artery Disease								1 year		
. Box 68760,	death certificate be executed e attending physicien and d for use as the burial-transit	Physician/Medical E	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	d	2 Fetal deat		Ectopic Other (:	pregnancy				23d. Date of delive	ery Day Year
ls, P.O.	ires that the de signed by the a I be detached f	by	9 □Unknown  Part II. Other significant conditions on  Type II Diabete:	ontributing to death bu	_			-				_	he cause of death?
Vital Records,	The law requires that the death cer ate has been signed by the attendir page 2 should be detached for use	Completed	Pulmonary Disea							24a. Was	an psy ormed?	24b. Were auto prior to co death?	opsy findings available impletion of cause of
Division of Vita	Hospitel or Attending Physicien: The Is 4 hours effer death. Funerel Director: After this certificate ha tely filled in by the funeral director, page 4	To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending investigation	Hospital: 1 Inpatie  28a. Date of Injur (Month, Day	v 28b.	Outpatient Time of Injury	3□ C	OA Other 28c. Injury a Work?	4 Nursing	Home 5 Res	dence	6 ☐Other (Specifury occurred	(y)
Divisi	spitel or Attendours efter deatlers level Director:	27. Manner of Death  1 Natural  2 Accident  3 Suicide  4 Homicide  28. Date of Injury  (Month, Day Year)  28. Imme of Norwy  Work?  1 Yes  28. Place of Injury  4 Home, farm, street, lactory, office  28. Place of Injury - At home, farm, street, lactory, office								28f. Location ( City or To		nd Number or Rura e)	al Route Number,
	To the Hospitel within 24 hours e To the Funerel I completely filled	Medical	(Check only 2 Medical Examone)	ysician: To the best on iner: On the basis of and manner sta	examination a		estigatio	n, in my opi	nion, death occ		date an	d place, and due to	o the cause(s)
Þ	2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	2	29b. Signature and title of certifier  Wyllian: 14	Silven		<b>9</b>		DO	027985			ril 5, 20	
	Sta	to	30. Name and address of person who of William Silverman 31. Date liled (Month, Day, Year)	n, M.D.	1201 S	even	Loc	ks Ro	ad, #11	1, Rocky	/ill	e, Maryla	and
	Regist		APR 1 1 200		K	Local	120						

Ariel Abramov 05-02687

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1- State Unpend Item 23a&27 per me G843 5-17-05 tas Registrar Registrar **RPD** 1 Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death 2005 April 16, **Physician** 2215 P Ariel Rachel ABRAMOV /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery General Hospital Olney Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

Months Days Hours Min. Sept. 24, 1991 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months California 1 □ M 2 □√F 609-58-1468 13 Director Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10a State 10d. Inside City Limits 28e-f show treumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director Maryland Silver Spring Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 14008 Beechvue Lane 20906 United States Items 23a Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status offled within 72 hours after de I Hygiene. Other then "naturel", or Item Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: white þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Student Education 1.2 should be filed with and Mental Hygien 7 Is marked other th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Igor Abramov Cynthia Remedios ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 sment of Health an 14008 Beechvue Lane, Silver Spring, MD Igor Abramov, Father 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 04/20/05 1X Burial 2 ☐ Cremation 3 ☐ Removal from State ō permit. Page Department of Importent: If any injury or once. Judean Memorial Gardens Olney, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Torchinsky Hebrew Funeral Home 254 Carroll St., NW, Washington, DC 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician a Mitochondrial complex I deficiency /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate raises (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Box 68760. Physician/Medical as IF FEMALE esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🔊 No Day ģ Month Year 5 Other (specify) 4☐Pregnant at time of death P.O. the detached 9 Unknown 9 Unknown þ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, by 2 X No 1 Tes 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of ceath?

1 ★ es 2 □ No 24a. Was an certificate has autopsy performed? page 1 Ves 2 No Division of Vital Hospitel or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Yes 2 No P 1 Inpatient 2XER/Outpatient 3 DOA this 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation Injury 1 X Natural death. 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide after 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 X Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) within 2 To the 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) 0 April 17, 2005 OCME death (Item 23a) (Type, Print) 30. Name and address 111 Penn Street Baltimore, Maryland 21201

State

Registrar

31. Date filed (Month, Day, Year)

Registrar's Signature

2005

20

			1- State of Maryland / Department of Health and Certificate of Death		ene () ()	5   390
	Physici	an	Decedent's Name (First, Middle, Last)	2. Date of Death	_	3. Time of Death
	/Medi		Mary Jane Armstrong	April	10° 20	05 8:23 A M
	Examir	ier	. 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deat		4c. County of	
			Homewood Retirement Center Williamspor  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year   If Under 24 Hrs			shington
	Funeral Director		220-28-8459 1 M 2X F 72 Yrs. Months Days Hours Min.			Birthplace (State or Foreign Country)     Maryland
	and and		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	Mary Find	to	Maryland Washington Williamsport			1 XYes 2 No
	r 28a	Director	10e. Street and Number 10f. Zip Code	10	g. Citizen of Wha	at Country?
	23e c		124 South Vermont Street 21795		U	SA
	r dea	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (S	Specify Yes or No- to Rican, etc.)	14. Race -	American Indian, White, etc.
Maryland 21215-0036	be filed within 72 hours after death with the Maryland stal Hygiene. So other than "neturel", or items 23e or 28e-f show event, it a Medical Examirat must be required as	by Fi	1 □ Never Married 2 ◯ Married 1 □ Yes 2 ◯ No   I Yes, Give   1 □ Yes 2 ◯ No   I Yes, Give   1 □ Yes 2 ◯ No   I □ Yes 2 ◯ No	, , , , , , , , , , , , , , , , , , , ,	Specify:	
2-0	72 ho	ted	15. Decedent's Education  (Specify only highest and a completed)  16a. Decedent's Usual Occupation  (Specify only highest and a completed)	16	6b. Kind of Busir	White ness/Industry
2	within ene.	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  (Give kind of work done during most of wo	rking		
121	filed w Hygier ther th		12 Nursing Assistant 17. Father's Name (First, Middle, Last) 18. Mother's Name			ical
anc	ntal Hed ot	Be		me (First, Middle, Ma	,	
Ž	shoutd by	2	Richard Raymond Harper Mildr  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or RI	ed Cathe		
	nd 2 should alth and 27 is murit		Barbara Kelley - Daughter15701 Fenton Avenue		•	
Baltimore,	nit. Pages 1 and 2 should artment of Health and Mer ortent: If item 27 is marke injury or other traumatic 8.		20a. Method of Disposition 20b. Place of Disposition (Name of	Date 20	Oc. Location - Cit	ryland 21795 by or Town, State
<u><u>E</u></u>	Pages ment of ent: If it ury or o		1 Burial 2 Cremation 3 Removal from State  '4 Donation 5 Other (Specify)  Green lawn Mem. Park April	13,2005	William	sport.Marylan
Salt	permit. Pages Department of Importent: If i any injury or once.		21. Signifure of Flineral Service Gos see	ome, P.A.	THE TOTAL	opor ryriar y ran
_	ZO = # 3		lay ( 425 S. Conococheag			ort,MD 21795
W.	Prrysician /Medical Examiner		23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart fallure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence of):			Approximate Interval Between Onset and Death MONAL
	Examiner	Į.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying  b			
	uted I Insit	Examiner	Cause (Disease or injury			
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8760,	ate be nysicia he bu	dlcal	d.			
9		Med	IF FEMALE:			
Вох	death certifi e attending j id for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?		23d. Date of Month	f delivery Day Year
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ds, P	ires that the death signed by the atte d be detached for		Part II. Other significant conditions/contributing to death but not resulting in the underlying cause given in Part I.			te to the cause of death?
0.00	w requir been si should	eted	1) (Cold vertical regard	1 🗆 Yes	2500 3	Probably 4 Unknown
Vital Record	The la ate has page 2	Completed by	house was	24a. Was an autopsy performe	d? prior	e autopsy findings available r to completion of cause of th? Yes 2 \sum No
/ita	Physician: Th this certificate ral director, pag	Be (	examiner:	ith (Check only one)		
	Physic this c	2	1 ☐ Yes No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Nursing H	lome 5 Residence	e 6 Other (	Specify)
UC.	ding P. After funer	lon	27. Manner of Death  1 Natural 5 Pending (Month, Day Year)  28a. Date of Injury 28b. Time of Injury Work?  1 Negretary investigation  M 28c. Injury at Work?  1 Yes 2 No	28d. Describe how	injury occurred	
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2	el or A s after Il Direction by	erti	4 ☐ Homicide building, etc. (Specify)	City or Town, S	State)	, ridia, riodio ridilibor,
	To the Hospitel or Attenwithin 24 hours after deatl To the Funerel Director: completely filled in by the		29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place 2 Medicel Examiner: Certifier Passis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medicel Examiner: Certifier Passis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medicel Examiner: Certifier Physician: To the best of my knowledge, death occurred at the time, date and place 2 Medicel Examiner: Certifier Physician: To the best of my knowledge, death occurred at the time, date and place 2 Medicel Examiner: Certifier Physician: To the best of my knowledge, death occurred at the time, date and place 2 Medicel Examiner: Certifier Physician: To the best of my knowledge, death occurred at the time, date and place 2 Medicel Examiner: Certifier Physician: To the best of my knowledge, death occurred at the time, date and place 2 Medicel Examiner: Certifier Physician: To the best of my knowledge, death occurred at the time, date and place 2 Medicel Examiner: Certifier Physician: To the best of my knowledge, death occurred at the time, date and place 2 Medicel Examiner: Certifier Physician: To the best of my knowledge, death occurred at the time, date and place 2 Medicel Examiner: Certifier Physician: To the best of my knowledge, death occurred at the time, date and place 2 Medicel Examiner: Certifier Physician: To the best of my knowledge, death occurred at the time, date and place 2 Medicel Examiner: Certifier Physician: To the best of my knowledge, death occurred at the time, date and place 2 Medicel Examiner: Certifier Physician: To the best of my knowledge, death occurred at the time, date and place 2 Medicel Examiner: Certifier Physician: To the best of my knowledge, death occurred at the time, date and place 2 Medicel Examiner: Certifier Physician: To the best of my knowledge, death occurred at the time, date and the time at the time at the time at the time at the time at the time at the t	, and due to the caus	se(s) and manne	or as stated.
	To the H within 24 To the F complete	<b>l</b> edical	The state of the s	rred at the time, date	and place, and	due to the cause(s)
	vith Com	Σ	29b. Signature and title of certifier  29c. License number	29d	Date signed (M	fonth, Day, Year)
			06650	6 /1	pril 1	0,000
61	(-1		30 Name and address of berson who completed cause of death (Item 23a) (Type, Print)	K		12/2/747
	Sta	te	31. Date filed (Month, Day, Vear) 32. Registrar's Signature	11296	Mari	1.000
	Registr	* + E	APR 1 2 2005 Januar S. Sperder	1		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrate Property (13/05, EW), McCo Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Year Robert Edwin Burnett April 6, 2005 10:15pm<sup>M</sup> /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Rockville Shady Grove Adventist Hospital Montgomery 8. Date of Birth (Month, Day, Year) 5. Social Security Number 259-28-1576 258-28 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 6. Sex Birthplace (State or Foreign Country) **Funeral** 1⊠M 2□F Months Days Hours Director March 13, 1928 Georgia Usual Residence of Decedent the Maryland show 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylas Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Evantiner must be notified at once. Director 1 ☐ Yes 2X No Maryland Montgomery Darnestown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 15404 Jones Lane 20878-3515 Funeral White 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: Korean Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 25 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: þ Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Dir. of Employee Relations Aerospace 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ပ Louis Gainey Burnett Donna Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Elsie A. Burnett (Wife)</u> 15404 Jones Lane, Darnestown, MD 20878-3515 20b. Place of Disposition (Name of cometery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ICremation 3 ☐ Removal from State \* 4 □ Donation 5 □ Other (Specify) Metropolitan Crematory 4/8/05 Alexandria, Virginia 22. Name and Address of Facility DeVol Funeral Home Signature of Funeral Service Licensee 10 East Deer Park Drive Gaithersburg, MD 20877 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Sepsis /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 physician buri Completed by Physician/Medical as attending ( use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) detached 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? sign 1 be Emphysema 1 ☐ Yes 2 ☐ No 3 M Probably 4 ☐ Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? page 2 s certificate has 1 Yes 2 X No 2 💢 No 1 Tes Physician: director Be 25. Was case referred to medical examiner? 26. Place of Death Check onl. one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: P 1 ☐ Yes 2X No 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After Hospital or Attanding 1 X Natural Injury 5 Pending after death. 1 Tyes 2 □ No investigation 2 Accident filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only within 2 To the 29b. Signature and title of cortifler 29c. License number 29d. Date signed (Month, Day, Year) 0 D 0061681 April 7, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 1/2001

2005 11

31. Date filed (Month, Day, Year)

Robert Kirkcaldy, MD 9901 Medical Center Drive, Rockville, MD 20850

Registrar's Signature

	•	1 - For State Registrar	State of Ma		partme <i>ertifica</i>			Mental Hy	/giene	000	-	13003
		Decedent's Name (First, Middle, Last	1)					2. Date of De	eath		<u>/</u>	3. Time of Death
Physicia		Johnny C. Brooks,	Sr.					Month April	0.5		005	3:30 A <sup>M</sup>
/Medic Examin		4a. Facility Name (If not institution, give			4b. Cit	y, Town, or	Location of Death			County of		
Examili	•	Suburban Hospital			Betl	nesda			Mo	ontgo	nery	
Funeral		5. Social Security Number 6. Se	7. Age	(In yrs. last birthda	y) If Und Months	er 1 Year Days	If Under 24 Hrs. Hours Min.	8. Date of Bi	av. Year)	9	Birthpla	ce (State or Foreign y) n Carolina
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	Į.	11. Marital Status  1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 [3] No		If Yes, sp	ecify Cuba	ispanic Origin? (Si an, Mexican, Puert	Rican, etc.)			White, et	
	by F	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 🗆 Yes	2 🔀 No	Specify:			Specify:	Bla	ck
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İ	Completed	12			Secu	rity			Fee	deral	Gov	ernment
	Be	17. Father's Name (First, Middle, Last)					18. Mother's Nan					
	ToE	Silas Brock					Vinnie	Brown/H	unte	r/Bro	oks	
		19a. Informant's Name/Relationship (7			•		and Number or Ru					Code)
		Phil Brooks / Son					rive, Ch					
		20a. Method of Disposition 1	Removal from State	20b. Place of Dis cemetery, c	sposition (N crematory of	ame of other plac	28)	Date	20c. Lo	cation - Cit	y or Tow	n, State
0		`4 □Donation 5 □ Other (Specify		Harmony				9/2005				
any Injuryor other treumatic ev		21. Signature of Funeral Sac ce Licen	60									Home, Inc.
5 2 9		John 1	Luci	and .	11800	New	Hampshir	e Ave.	Silv	er Sp	ring	, MD 20904
		23a. Part1. Enter the disease, or composition of heart failure. List only	olications that caused to one cause on each line	he death. Do not o	enter the m	ode of dyin	ig, such as cardiad	or respiratory	arrest,		1	Approximate interval Between Onset and Death
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5	Physician/M	23b. Was decedent pregnant in the past 12 months?	1☐Live birth 2 4☐Pregnant at t		3 □Ectopic 5 □ Other (		/			Month		Day Year
ched	ıys	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9□ Unknown		,							
be detached		Part II. Other significant conditions of	ontributing to death bu	t not resulting in the	e underlying	cause giv	en in Part I.	23e. Did	tobacco	se contribu	ite to the	cause of death?
90 0	d by	Myocardial Infarc	tion					1 🗆	Yes 2	□ No 3	Proba	bly 4 Donknown
should	Completed	Consis						24a. Wa	s an	24b. We	re autops	sy findings available
99 2	Ę	Sepsis						perf	opsy formed?	dea	th?	pletion of cause of
or, pa	CC	25. Was case referred to medical					26. Place of Dea	1 Yes		1-	Yes 2	11 NO
funeral director, page	o Be	eyaminer?	Hospital:	t 2 ER/Outpa	tient 3 🗆 I	Oth		lome 5 Res		6 □Other	(Specify)	
aral d	-	27. Manner of Death	28a. Date of Injury (Month, Day		e of	28c. Injur		28d. Describe			Opecity)	
funer	tlor	1 Natural 5 Pending 2 Accident investigation		Year) Injur	y M		k? Yes 2 □ No					
y the	flea	3 ☐ Suicide 6 ☐ Could not be	286. Place of inju	ry - At home, farm,	street, factor	ory, office		f. Location	(Street ar	d Number	or Rural	Route Number,
	Certification:	4 Homicide determined	building, etc.	. (Specity)				City or To	own, State	1)		
		(Check only 2 Medical Exam	ysician: To the best o	examination and/or								
completely filled in by the fu	Medical	one)	and manner stat			9c. Licens				te signed (/		
3		29b. Signature and title of certifier	$\gamma \gamma \wedge$		2	1	61631		14	151	05	_,, , , , , ,
		, /(c. a				100	0100		-1	11		
		30. Name and address of person who				-	1 5	. 1		1 00	0.51	
		Natasha Chen, M.D		Old Goe			ad, Beth	esda, Ma	aryla	and 20	ולאו	
Sta		31. Date filed (Month, Day, Year)	37 Registra	r's Signature	care	7.						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** BORDLEY LUCINDA APRIL 10 2005 7:36p Α. /Medical 4c. County of Death 4b City Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Chestertown Kent Chester River Manor Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Days Months Hours 1 ☐ M 2 1 ☐ F 95 Yrs. 1909 July Maryland Director 213-24-1042 Usual Residence of Decedent 10d. Inside City Limits 10c, City, Town or Location 10a. State 10b. County r than "natural", or Items 23a or 28a-f shov the Medical Express must be notified at 1 ☐ Yes 2 ☑ No Director Kent MD Chestertown 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 21620 U.S.A. 8385 Broadneck Rd. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status filed within 72 hours after 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: Specify: **Black** ğ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Domestic Worker Someone else's home 8 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 Is marked oths any injury or other traumatic event, 90ce. 17. Father's Name (First, Middle, Last) Hannah Watson German Teat 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8 Edgemont Lane Durham, NC. 27701 Albert Teet (nephew) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a, Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Ewingtown Cemetery 4/15/05 Ewingtown, MD. \* 4 ☐ Donation 5 ☐ Other (Specify) Galena Funeral Home of Stephen L. Schaech 118 West Cross St. Galena, MD. 21635 21. Signature of Funeral Service Licensee M00510 Approximate Interval Between Onset and Death Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) deri **Physician** neumama /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Physician: The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): by Physician/Medical 23c. If yes, outcome of pregnancy 1 □Live birth 2 □ Fetal death 4 □ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav Year in the past 12 months? 5 ☐ Other (specify) 9 Unknown 9 Dunknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Rt 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed peeu 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No 24a. Was an autopsy performed? Yes 2 No has Advanced Service Dementie, CRF, CHT. this certificate 1 ☐ Yes completely filled in by the funeral director, 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Mannes of Death 28b. Time of s after death. If Diractor: After th Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours a To tha Funeraf I To the Hospital 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medicai 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 41/llun MD.

State Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

415 Washington Ave. Chestertown, MD. 21620

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Kin Kue Wun, M.D.

31. Date filed (Month, Day, Year)

APR 1 3 2005

		1 - State Registrar		C	ertifica	e of D	eath	105: 15	Reg. No.20	05	1390
Physicia		1. Decedent's Name (First, Middle, Last)  James J. Blaney						2. Date of De Month April	7, 20	Year 05	3. Time of Death 6: 28a
/Medic Examin		4a. Fecility Name (If not institution, give s Howard County Gene	treet and number) ral Hospit	al	-	Town, or L	ocation of Death	<del></del>	4c. County		1
Funeral Director		213-30-0739	M 2DE	70 Yrs	Months		If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da 2/11/1	th ay, Year) .935		place (State or Fore outry) Yland
aryland show	_	Usual Residence of Decedent  10a. State 10b. County	1	Oc. City, Town of						1	10d. Inside City Lin
be filed within 72 hours after death with the Maryland Hygiene. A the Hygiene do ther than "natural", or items 23a or 28a-f show do ther than "natural", or items 23a or 28a-f show event, Ite Medical Examinar most be notified at	Irecto	Md. Howard  10e. Street and Number		Dayto		Code			10g. Citizen of	What Cour	
s 23a	eral D	4330 Linthicum Ro		orio II S	12 Wes Dass	2103		acity Vac as Na	US		en Indian,
Department of Health and Mental Hygiene. Important: or items 23a or 28a-f show Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Ite Medical Exactinational be notified at once.	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:	91 III U.S.	If Yes, spe		anic Origin? (Sp Mexican, Puerto Specify:	Rican, etc.)	Bla	ck, White,	
n "natur Medical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or 5+)	16a. De (G lif	ecedent's Usu Rive kind of wo re. DO NOT L	al Occupati ork done dui se retired)	on ring most of work	king	16b. Kind of B	usiness/In	dustry
lygiene her tha nt, It e	Com	11			Firef					scue	
ked otl	To Be	17. Father's Name (First, Middle, Last)  James J. Blan	ey Sr.			1		C. Feac	, Maiden Sumar (a.	ne)	
and M is mar aumati	Ţ	19a. Informant's Name/Relationship (Typ		19b. M	ailing Addres	(Street and			er, City or Town,	State, Zip	Code)
om 27 ther tr		Anthony P. Blaney, 20a. Method of Disposition	/son	1552 20b. Place of Di	20 Catt	ail C	aks Gle	nwood,M	d. 21738		own State
y or o		1 ☑Burial 2 ☐ Cremation 3 ☐ Re '4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	20b. Place of Dicemetery, of St. Lou				/2005	Clarks		
Importan any injur once.		21. Signature of Funeral Service License	1 7		22. Name a	nd Address	of Facility Ha	rry H.W	itzke's	Fami.	ly F.H.I
260		23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	MOLS MO		enter the mod	old Co	lumbia 3	Pike El	licott (	ity,	Md.21043 Approximate
sician		shock, or heart failure. List only on Immediate Cause (Final disease or condition		Myocardi							Onset and Deat
Physician /Medical Examiner		resulting in death)		consequence of):		arciti	OII				
¢.	- L	Sequentially list conditions, if any, leading to immediate	Severe Due to (or as a	Chronic consequence of):	Obstr	ctive	Pulmona	ary Dis	ease		
nd ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Diabete	s Mellit	us						
physician and the burial-transit	cal Ex	resulting in death) Last		consequence of):							
physician is the buria		<b>\</b> d	Hyperte	IISTOII							
/ the attending pl ched for use as t	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of 1 Live birth 2 4 Pregnant at tir 9 Unknown	Fetal death	3 Ectopic p 5 Other (s)					te of delive	ory Day Year
n signed by the a uld be detached f	d by Ph	Part II. Other significant conditions con Pulmonary Emboli		not resulting in th	e underlying	ause given	in Part I.				ne cause of death
ate has been si page 2 should l	omplet	Deep Venous Thro	mbosis					24a. Was auto perfo	an 24b. psy prmed? 2 Z No	Were auto prior to con death? 1  Yes	psy findings avail mpletion of cause 2 No
24 hours after death. Funeral Director: After this certificate has been signed by the attending phy tely filled in by the funeral director, page 2 should be detached for use as th	Be	25. Was case referred to medical examiner?	ospital: 🕶			Othor	6. Place of Deat				
eral dir	n: To	1 ☐ Yes 2 ☒ No	ospital: 12 Inpatient  28a. Date of Injury (Month, Day)			28c. Injury a Work?			dence 6 Oth		y)
or: Afte	atio	1 Natural 5 Pending 2 Accident Investigation	(Month, Day )	/e <i>ar)</i> Injui	ny M		s 2□No				
l Direct d in by t	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc.	- At home, farm, (Specify)	, street, factor	y, office		28f. Location ( City or To	Street and Numb wn, State)	er or Rura	l Route Number,
within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical C	29a. Certifier  (Check only one)  2 Medical Exemin	icien: To the best of ter: On the basis of e and manner state	xamination and/o	eath occurred ir investigation	at the time, , in my opin	date and place, ion, death occur	and due to the red at the time,	cause(s) and made and place,	and due to	tated. the cause(s)
	2	29b. Signature and title of certifier			29	c. License n	umber		29d. Date signe	d (Month,	Day, Year)
To the	-	Λ / .	M.D.			D0056					

ORIGINAL

			1 - For State Registrar		ryland / Depa		lealth and M	lental Hy	giene Reg. No.	05	139	906
П	Physici	an	Decedent's Name (First, Middle, Las	,				Date of De Month	Day	Yeer	3. Time of	
	/Medic			Barbara	E. Behn			April		2005	4:15	A M
	Examir	er	4a. Facility Name (If not institution, give				r Location of Death			ty of Death		
_			4826 Roundhill Roa		(In use in at historia)	ELL10	cott City	a Data at Dia		ard	(2)	
Ü	Funeral Director		5. Social Security Number 6. Security Number 216 36 7437	m 2₹F	65 (In yrs. last birthday)	Months Days	Hours Min.	8. Date of Bir (Month, Da Oct 2,	1939	North North	ece (State of try) Caro	lina
	land ow		10a. State 10b. County		10c. City, Town or Lo	ocation				10	Od. Inside Cit	ty Limits
	be filed within 72 hours after death with the Maryland tal Hygiene. Id other than "natural", or items 23a or 28a-f ehow event, the Medical Erans are intest be conflied at	ţo	MD Howard	l	Ellicot	t City					1 ☐ Yes	2 <b>1</b> 0
	r 28g	irec	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Coun	try?	
	23a c	Funeral Director	4826 Roundhill Ro	ad		2104	13		Unit	ed Sta	ites	
	ems errin	Iner	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S. 13.	Was Decedent of H	lispanic Origin? (Spe an, Mexican, Puerto	cify Yes or No Rican, etc.)	- 14. Ra	ace - America		
36	or It	by Fu	1 Never Married 2 Married	1 ☐ Yes 2 🛣 N If Yes, Give	0	1 Yes 2 XNo			Spec	ih n		
Ö	72 hours after natural', or Ite		3 Widowed 4 Divorced	Year or Dates:	100					WI	ite	
5	n 72 "na	lete	15. Decedent's Ed (Specify only highest grad		16a. Dece (Give	dent's Usual Occup kind of work done DO NOT use retired	ation during most of worki d)	ng	16b. Kind of I	Business/Ind	ustry	
12	within iene. then	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)	d Clerk	-,		Groce	erv		
9	e filed within al Hygiene. I other than ' vent, I've Me	Be C	17. Father's Name (First, Middle, Last)		1		18. Mother's Name	(First, Middle,				
lan	should be nd Mental marked o	To B	Earl Harrell				Frances	Kale				
Maryland 21215-0036	2 shou and M is mar aumat	-	19a. Informant's Name/Relationship (7	ype, Print)	19b. Maili	ng Address (Street	and Number or Rura		er, City or Town	n, State, Zip	Code)	
	ges 1 and 2 should t of Health and Mer If Item 27 is marks or other traumatic		Roland C. Behn/Hu	ısband	4826	Roundhil	l Road El	licott	City, I	MD 210	43	
ore	of Health of Health litem 27 i		20a. Method of Disposition  1 Burial 2 Cremation 3 D	D	20b. Place of Dispo cemetery, crei	sition (Name of matory or other place	ce)	ate	20c. Location	- City or To	wn, State	
Ē	Page nent ant: Il		1 ☐ Burial 2 ☑ Cremation 3 ☐ 1 ☐ Donetion 5 ☐ Other (Specify)		Metro Cr		4-13-	2005	Catons	ville,	MD	
Baltimore,	permit. Pages 1 Department of H Importent: If Ite any Injury or ot once.		21. Signature of Funeral Service Licen	see	M01044 22	2. Name and Addre	ss of Facility Har	ry H. W	litzke':	s Fami	ly FH	Inc.
<b>m</b>	80E 2 8		Home Jellen	With	4	112 Old C	olumbia P	ike Ell	icott (	City,	MD 210	)43
	Certificate be executed having physician and fundaminer as the burial-fransit	Examiner	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of limits and control of the control	a. Due to (or as a b. Due to (or as a c.	a consequence of):			_			Approximate Interval Betv Onset and D	мееп
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687	ficate p phy: as the			0								
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	w requires that the been signed by th should be detache	d by Pł	Part II. Other significant conditions co	ontributing to death bu	t not resulting in the u	nderlying cause grv	en in Part I.		obacco use cor	ntribute to the		eath?
of Vital Records,	The law ate has b page 2 s	Complet								Were autop prior to com death? 1 Yes	pletion of ca	ivailable iuse of
/ita	cian: artific actor,	Be (	25. Was case referred to medical examiner?				26. Place of Death	(Check only o	ne)			
<u>}</u>	Physician: this certific ral director,	2	1 ☐ Yes 2 🔀 No		nt 2 ER/Outpatier		4 🗆 Ruising Hor	ne 5X Resid	lence 6 □Ot	her (Specify,		
ion o	Attending P r death. ector: After t by the funera	ation:	27. Manner of Death  1 ☒Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injun (Month, Day	M 1	yat k? Yes 2 □No	8d. Describe h	ow injury occu	rred			
Division	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju building, etc	ry - At home, farm, str . (Specify)	eet, factory, office	2	8f. Location (S City or Tox	Street and Num m, State)	ber or Rural	Route Numb	oer,
	the Hosp hin 24 hou the Funer npletely fil	Medical	29a. Certifier 1 Mail Certifying Phy (Check only one) 2 Medical Exam	vsician: To the best o iner: On the basis of and manner stat	examination and/or in	n occurred at the tin vestigation, in my o	ne, date and place, a pinion, death occurre	and due to the ded at the time, o	cause(s) and m date and place,	anner as sta , and due to	ted. he cause(s)	
	To the to the total	Σ	29b. Signature and title of certifier	1		29c. Licens			29d. Date signe	ed (Month, E	ay, Year)	
			CWU	ole M	D	DI	6354		April	. 11, :	2005	
			30. Name and address of person who c	and NES	ath (Item 23a) (Type, 900 CI	Print) TON AL	IE BA	LTIMOR	RE M	0 2	1229	3
	Sta Registr		31. Date filed (Month, Day, Year) APR 1 2 20	32 Abgistra		ant b					*	

			1 - For State Registrar	State of Marylan		artment of h			ene 005	13907
	Physici		1. Decedent's Name (First, Middle, Las BERNADETT	·		BAKE		2. Date of Death Month	Day Year	3. Time of Death
l.	/Medio Examin		4a. Facility Name (If not institution, give	street and number)	16	4b. City, Town, of FREDE	or Location of Death		4c. County of Dea	th
	Funeral Director		46-06-0107	ex	last birthday) Yrs.	If Under 1 Year Months Days		8. Date of Birth (Month, Day, )	(ear) 9. Bir (951	thplace (State or Foreign ountry)
	h the Maryland r 28a-f show r notified at	Director	Usual Residence of Decedent  10a. State  10b. County  FREDER		y, Town or Lo					10d. Inside City Limits 1
	ath with the 23a or 28a ust by noti	rai Dire	10e. Street and Number 6745 /LE/	ENEL COU	RT	10f. Zip Code	21703	100	g. Citizen of What Co	
5-0036	hours after dez tural', or Iteme el Exeminer m	by Funeral	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 1 No	Hispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, Whit	te, etc.
<b>0-6121</b>	within 72 ho lene. than "natur he Medical	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)		(Give	DO NOT use retire	during most of wor	king		Andustry OF CORREGAN MARYLAND
ylandz	ould be filed Mental Hygi arked other atic event, I	To Be C	17. Father's Name (First, Middle, Last)  MOSES  B	<del></del>			18. Mother's Nam  MARIE	ne (First, Middle, Ma	aiden Sumame)	
, Mar	and 2 she leelth and m 27 is m			BAKER	674	5 Kten	CL COURT	FREDERI	City or Town, State.	21703
timore	it. Pages I rtment of H rtant: If Ite njury or ot		20a. Method of Disposition  1 Burial 2 December 3 0  4 Donation 5 Other (Specify  21. Signature of Funeral Service Licego	5m	Misbur	osition (Name of matory or other pla	ay April	8, 2005 5	oc. Location - City or his burd	
g D	Depa Depa Impo any ii		> Buy 2. K	olleis	110	WEST &	SOUTH ST	NORAL H	ce mo	4101
	Physician / Medical Examiner	Examiner	23a. Part. Enter the disease, or some shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	one cause on each line.	uence of):		-	Daser		Approximate Interval Between Onset and Death
Box 68/60	9 × 9	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 0 No	d. 23c. If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of d	death 3	□Ectopic pregnanc	у		23d. Date of del	livery Day Year
rds, P.O.	w requires that the death certifica been signed by the attending ph should be detached for use as th	by	9 ☐ Unknown  Part II. Dther significant conditions c	9□ Unknown ontributing to death but not res	ulting in the u	inderlying cause giv	ven in Part I.	23e. Did toba	0.2	o the cause of death?
ľ	i: The law rer icate has bee r, page 2 sho	Completed						24a. Was an autopsy performe	prior to	utopsy findings available completion of cause of
r Vital	lysicier is certif directo	To Be	25. Was case referred to medical examiner?  1  Yes  2 No	Hospital: 1   Inpatient 2	ER/Outpatier	nt 3 DOA Ott		th (Check only one) ome 5 Resident	ce 6 Other (Spe	cifv)
Division of	r Attending Physicien: The laver death. rector: After this certificate has by the funeral director, page 2	Certification:	27. Manner of Death  1 Natural 5 Pending  Accident investigation  3 Suicide 6 Could not by		28b. Time o Injury	Wo	ry at	28d. Describe how		
Ž	oitel or Attendir urs after death. orel Director: Af illed in by the fu	Certifi	4 Homicide determined	building, etc. (Specify	y)			City or Town,		
	To the Hospitel or within 24 hours after To the Funeral Director Completely filled in E	Medicai	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Example one)	ysicien: To the best of my kno niner: On the basis of examina and manner stated.	wledge, deat tion and/or in	h occurred at the til evestigation, in my o	opinion, death occu	rred at the time, date	e and place, and due	to the cause(s)
	\$ <del>`</del> \$ <del>`</del> \$	_	> XNN/L	Lassim		D-1	1397/		Date signed (Mont	) S
	1		Robert L. Kaufma			ST FRE	Xthick, M	0 21701		
	Sta Begisti		31. Date filed (Month, Pay R eak) 8	2005 32. Registrar's Signa	ture	A				

		-	For State Registrar			Certificate of		Mental Hygi	g. No.	15	13908	
			Decedent's Name (First, Middle,	Last)				2. Date of Death	1		3. Time of Death	
F	hysicia		Virginia M.	Baisev				April	7, 20	Year 005	8:35 P M	
	Medic/ Examin		4a. Facility Name (If not institution,		ər)	4b. City, Town, o	r Location of Death	1	4c. County	of Oeath		
			Glade Valley Nu	rsing Home	e	Walke:	rsville		Fre	ederi	ck	
F	uneral			. Sex 7.	Age (In yrs. last birth	day) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year)	9. Birthpl	ace (State or Foreign try)	
	rector		577-03-8150	1□ M 20XF	92 Yr	s. Worth Bays	TIOUIS IVIII.	May 5,	1912	Virg		
pu	2	-	Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	or Location		<del></del>		1/	Od. Inside City Limits	
aryla	shoy to at	-	,							1	1 Yes 2 □ No	
he M	ctiffic	Director	Maryland Frede	erick	Myer	sville		1.10	g. Citizen of V	Ath-sh Cours		
with	LED		809 Rocky Founta	in Drive		10f. Zip Code	1773	"			-	
death with the Maryland	18 23	era	11. Marital Status	12. Was Decede	nt Ever in 11 S			necify Vee or No-	United	e - America		
ter di	Itar	Funeral	1 Never Married 2 Married	Armed Force	s?	<ol> <li>Was Decedent of H If Yes, specify Cuba</li> </ol>	an, Mexican, Puerto	Rican, etc.)		k, White,		
within 72 hours after ene.	od other than "natural", or itams 23a or 28a-f show avent, If a Medical Exercitrer court be notified at	by	3 Widowed 4 □ Divorced	If Yes, Give Year or Date		1 ☐ Yes 2 💢 No	Specify:		Specify	: Wh	ite	
13-0030	ature cal E	Completed	15. Decedent's		16a. C	ecedent's Usual Occup	ation	. 1	6b. Kind of Bu	usiness/Ind	ustry	
, in a second	n "n	ple	(Specify only highest Elementary/Secondary (0-12)	College (1-4d		Give kind of work done life. DO NOT use retired	during most or world)	King				
d with	ar the	mo:	8	35/13g5 (1 1 1 1		fice Clerk			Inst	iranc	e	
and A	othe	Be	17. Father's Name (First, Middle, La	ast)			18. Mother's Nam	ne (First, Middle, M	aiden Suman	10)		
yian ould be Mental	rked tic a	To	James Taylor				Katie	William	son			
Maryla d 2 should th and Men	le marked othar aumatic avent, I		19a. Informant's Name/Relationship	p (Type, Print)	1	Mailing Address (Street						
≥ 9 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5	itam 27 le marke other traumatic		James Baisey /	Son		09 Rocky F	ountain D	rive, My	ersvil]	Le, M	D 21773	
	If itan or oth	1	20a. Method of Disposition  1 ▼Burial 2 □ Cremation 3		cometen	Disposition (Name of crematory or other place	(8)	Date 2	Oc. Location -	City or To	wn, State	
Pages Pent of	ant: h		'4 □Donation 5 □ Other (Spe			y Cemetery	4/11	/2005	Bealls	ille	, Maryland	
<b>Baltimore,</b> permit. Pages 1 a	Important: If i any injury or once.		21. Signature of Funeral Service Lie	censee	0.1	22. Name and Addre	ss of Facility	Stauffer	Funera	1 Hom	e	
තු දීයී	E # 8		1 ourmen	Stary	ller	1621 Oposs	umtown Pi	ike, Fred	erick,	MD 2	1702	
			23a Part1. Enter the disease or co	omplications that caus	ed the death. Do no	t enter the mode of dyin	ng, such as cardiac	or respiratory arre	st,		Approximate Interval Between	
Phv	sician		Immediate Cause (Final disease or condition	( )	nach	· blea	X For V	111			nset and Death	
/M			resulting in death)	a		M 1 1 1 1						
Exa	/Medical resulting in death)  Due to (pras a consequence of);											
	Examiner  Sequentially list conditions.  b. Athliosclerote Cardiovoscula Dis											
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. att	as a consequence of as a consequence of	levotre	Carde	ovoscul	en des	ز	jears .	
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		l Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or	wion	lecotre	Carde	ovoscul	er des	į	frais	
		Ilcal Examiner	that initiated events	b. Due to (or	as a consequence of	lecotre	Carde	ovoscul	er des	į	frais	
	hysician and the burial-transit	dlcal	that initiated events resulting in death) Last	b. Due to (or d.	as a consequence of	lecotre	Carde	ovoscul	er Dis	i	frais	
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			For State Registrar	State of M	Maryland	•	artment of F			R	eg. No.	005	13909		
	Physicia	an	Decedent's Name (First, Middle, La	st)					l N	ate of Dear	Day	Year	3. Time of Death		
	/Medic	al	Andrew W. Boyd  4a. Facility Name (If not institution, give	re street and number	ar)		4b. City, Town, o	r Location o	Apı of Death	ril	9 4c. C	2005 County of Deat	10:45 A <sup>™</sup>		
	Examin	er	9 Woods Way	0 000000	.,		E1kton				Cec				
	Funeral		5. Social Security Number 6. S	Sex 7	Age (In yrs. las		If Under 1 Year Months Days	If Under Hours	24 Hrs. 8. D Min. (//	ate of Birth Month, Day,		9. Birtl	nplace (State or Foreign untry)		
	Director	-	201 07 1883  Usuel Residence of Decedent	IM ZLIF	84	Yrs.				2. 1,		Mary	land		
	land ow		10a. State 10b. County		10c. City,	Town or Lo	ocation						10d. Inside City Limits		
	e-fsh	ctor	Maryland Cecil		E1ktc	n							1 ☐ Yes 💥 No		
	or 28	Director	10e. Street and Number				10f. Zip Code			1	0g. Citize	en of What Co	untry?		
	eath v	Funeral	9 Woods Way	12. Was Decede	nt Ever in U.S.	. 13.	21921 Was Decedent of H	lispanic Ori	gin? (Specify )			d Stat			
က	or item		1 Never Married 2 Married	Armed Force	s?		If Yes, specify Cuba 1 ☐ Yes 2 No	an, Mexicar	i, Puerto Ricar	n, etc.)		Black, White	e, etc.		
21215-0036	72 hours after death with the Maryland naturel; or Items 23a or 28e-f show Scal Examinat must be natified at	d by	3X Widowed 4 ☐ Divorced	If Yes, Give Year or Date:	s:			Specify:				Specify: whi			
15-	"natu	Completed	15. Decedent's E (Specify only highest gr	ade completed)		(Give	dent's Usual Occup kind of work done DO NOT use retired	durina mos	t of working		16b. Kind	d of Business/l	Industry		
212	i within jiene. r then "	шо	Elementary/Secondary (0-12)	College (1-4d			ant Mari				011	Indust	rv		
힏	al Hygie t other vent, II	Be C	17. Father's Name (First, Middle, Last	)					er's Name <i>(Fir</i> s	st, Middle, I					
Maryland	2 should be and Mental is marked o	ဥ	Albert Peschau						1 Spend						
Mar	d 2 sh th and 7 is m treum	10.3	19a. Informant's Name/Relationship (				ng Address (Street						ip Code)		
ē,	s 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental hygiene if the Marylan Item 27 is marked other then "naturel", or items 23a or 28e-f show other treumatic event, I'm Madical Examinar must be mailined at		Irma McGee/Compar 20a. Method of Disposition	iion	20b. Pia	ce of Dispo	ds Way,		n, Mary Date			ation - City or	Town, State		
altimore,	1 ABurial 2 Cremation 3 Removal from State St. Mary Anne's Cemetery								April 1 2005	13,	Iorth	Fact	Maryland		
alti	permit. Departminente		21. Signature of Funeral Service Lice	Signature of Funeral Service Geensee 22. Name and Address of Facility Crouch Funeral Home											
8	20129		Mall Cu									st,Mary			
			23a. Part1. Enter the disease, or com shock, or heert failure. List only Immediate Cause (Final	one cause on each	sed the death. n line.	Do not en	er the mode ot dyin	ng, such as	cardiac or res	piratory arri	est,		Approximate Interval Between Onset and Death		
	Physician /Medical		disease or condition resulting in death)	и.	AONLA as a conseque	nce of):							DAYS		
	Examiner						ve purm	ONAKY	DISEA	56_			YEARS		
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	and -trans	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):									YEARS			
8760,	death certificate be executed e attending physician and nd for use as the buriat-transit	aiE		4								1			
9	tificate ig phy: as the	ledical													
Вох	eath certifica attending ph for use as th	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcor 1□Live birth	me of pregnand		Ectopic pregnancy	,			23	ld. Date of deli	very Day Year		
	he dea the at hed fo	ysici	1 Yes 2 No	4□Pregnant 9□Unknowr	tat time of dea n	ith 5	Other (specify) _					World	ouy rour		
P.O.	n requires that the di been signed by the should be detached		Part II. Other significant conditions	contributing to death	h but not result	ting in the u	nderlying cause giv	en in Part I		23e. Did tol	bacco use	e contribute to	the cause of death?		
rds	requires seen sign hould be	ed by	ASBASTOSIS							1 🗆 Ye	es 2 🗹	<b>№</b> 3□Pro	obabiy 4 🗀 Unknown		
of Vital Records,	es SO	Completed								24e. Was a autops		24b. Were au	topsy findings available completion of cause of		
Ĕ	The ate h page	Com							1	perforr	ńed? 2 ☑ No	death?	_		
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ō	Phys this ral di	© 5 C 1   res 2 2 No 1   Inpatient 2   EH/Outpatient 3   DOA 4   Nurs								5 Reside Describe ho			ify)		
ion	를 <sup>곧</sup> 돌 글	atio	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	n	Day Year)	Injury		k7 Yes 2 ☐	No						
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	e Hospitei 24 hours e Funerei letely filled	Medical		miner: On the basis and manner	s of examination										
and manner stated.  29b. Signature and title of certifier  29c. License number										signed (Month					
	DOOYTTU April							1 11,20	305						
	10		30. Name and address of person who	completed cause of				ELK	TON H	<b>\</b>	O nA	21921			
9	Sta	te	31. Date filed (Month, Day, Year)	. 22 Pagi	atraria Cianam	Ire	- 711 >					24.00	`		
	Registr		APR 1:2 2005	Gen >	T 19										

State of Maryland / Department of Health and Mental Hygien® Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year Shawn Ray 2358 M 2005 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Deeth COKINS Baltimore Johns Hospita 8. Date of Birth (Month, Day, Year) April 5, 2005 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** 1X1M 2 1 F Director None Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location worle 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Frederick Tuscarora 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 5501 Ferry Rd. 21790 230 U.S.A. Completed by Funeral or iteme. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 1 □ Yes 2 No Maryland 21215-0036 Specify: 3 Widowed 4 Divorced White "netural", 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. importent: if teen 27 is marked other then "ne eny injury or other traumatic event." Elementary/Secondary (0-12) College (1-4or 5+) n/a 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) not stated Tina Marie Beall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tina M. Beall - mother 5501 Ferry Rd., Tuscarora MD 21790 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Pipe Creek Cemetery 4/11/2005 ' 4 ☐ Donation 5 ☐ Other (Specify) near Linwood, MD 21. Significate of Funeral Service Licensee 22. Name and Address of Facility Hartzler Funeral Home attarine 404 S. Main St., Woodsboro, MD 21798 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Perinatal **Physician** Asphyxia /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a surisequence of). attending physician and for use as the burial-transit Due to (or as a consequence of): FAXTONE /OK PCF Shi / l Division of Vital Records, P.O. Box 68760, Physician/Medical as IF FEMALE esn 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetel death 3 Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death Month Day Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 1 🗌 Yes 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has autopsy perform 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA in by the funeral 27. Manner of Teath 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending death. investigation 1 ☐ Yes 2 ☐ No after death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a
To the Funerel D
completely filled i 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES - 000 MD 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 North Wolfe Greet, NICU Bhombal, MD Shazia Baltimore MD 2128 31. Date filed (Month, Day, Year) 32. Registar's Signature State APR 1 1 2005 Registrar

			For State Registrar	State of Maryla		artment of H		-	giene Reg. No.? 1115	13011
	Physici		1. Decedent's Name (First, Middle, La Olive Virg	,				2. Date of De Month		3. Time of Death
	/Medic Examir Funeral		,	rt Hospit	rs. last birthday,	4b. City, Town, or  If Under 1 Year  Months Days	Location of Deal	ind	y, rear) _   C	ath  COOL  Inthplace State or Foreign  Jountry)
	Director		Usual Residence of Decedent  10a. State 10b. County		Yrs.			April :	20 1925 Ma	aryland  10d. Inside City Limits
	the Maryl 28a-f sho	Director	MD. Allegar		Westerr	port			-	MXYes 2 □ No
	23a or		123 Main St.,	Apt. A		10f. Zip Code 2156	52		10g. Citizen of What C United Sta	
980	be filed within 72 hours after death with the Maryland ital Hygiene. d other than "natural, or Items 23e or 28e-f show event, the Nedfoal Evarrhan must be routified at	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 ₩ No	spanic Origin? (S n, Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)	14. Race - Am Black, Wh Specify: W	ite, etc.
Maryland 21215-0036	within 72 h ene. than "natu the Medical	Completed	15. Decedent's E (Specify only highest gir Elementary/Secondary (0-12) unknown	ducation ade completed) College (1-4or 5+)	(Give	dent's Usual Occupa kind of work done of DO NOT use retired memaker	furing most of wo	rking	16b. Kind of Busines:	
land 2	D 9 3 3	To Be Co	17. Father's Name (First, Middle, Las	(layhew			18. Mother's Na Helei		Maiden Sumame) ets	
	nd 2 sh alth and 27 ls m r treum	_	19a. Informant's Name/Relationship Sharon Wilhelm/ o						er, City or Town, State, Lonaconing,	
Baltimore,	Page nent o ant: If ury or		20a. Method of Disposition  XXXBurial 2 Cremation 3 [  4 Donation 5 Other (Special Contents)	Removal from State	cemetery, cre	osition (Name of matory or other place 1 Mem. Gar	140 Acob	/18/ 005	20c. Location - City o	
Balt	permit. Departr Importe any inji		21. Signature of Funeral Service Lice	nsee Sol		2. Name and Addres			eral Home rt, Marylar	nd 21562
	Physician /Medical Examiner	er	23a. Part1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate	c or respiratory ar		Approximate Interval Between Onset and Death				
8760,	cate be executed bhysician and the burial-transit	dical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a cons	equence of):					
P.O. Box 68	that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome of preg 1	etal death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year
	law requires that as been signed b 2 should be det	by	Part II. Other significant conditions			nderlying cause give	in in Part I.  FAI LUR		obacco use contribute t ∕es 2 □ No 3 □ P	o the cause of death?
Vital Records,	The ate h page	Completed						24a. Was a autop perfor 1 \( \text{Yes} \)	sy prior to med? death?	utopsy findings available completion of cause of
	Physicien: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner?  1  Yes 2 No	Hospital: 1 Inpatient 2	☐ ER/Outpatier	nt 3□ DOA Othe	_	ath (Check only or	ne)	ngih.)
	ling After une	atlon: T	27. Manner of Death  1 Matural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time or Injury	f 28c. Injury Work			ow injury occurred	слу)
Divis	iel or Atte s after des sl Directo ed in by th	Certification;	3 Suicide 6 Could not be determined		home, farm, str cify)	eet, factory, office		28f. Location (S City or Tow	Street and Number or R n, State)	ural Route Number,
	To the Hospitel or Attending Phwithin 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	edical	29a. Certifier Certifying Pl (Check only one) 2 Medical Exa	nysician: To the best of my k niner: On the basis of exami and manner stated.	nowledge, death	n occurred at the time vestigation, in my op	e, date and place inion, death occu	, and due to the c rred at the time, c	cause(s) and manner as date and place, and due	s stated. e to the cause(s)
	To t To t	Σ	29b. Signature and title of certifier	. A P		29c. License		1	29d. Date signed (Mont	
7	3		30. Name and address of person who	completed cause of death (It	em 23a) (Type,		6907	/	MPRIL 14, 9	005
	Sta	te.	Dr. Harit Sic 31. Date filed (Month, Day, Year)	1hu 925 B 32. Registrar's Sig	IShop nature	Walsh	Koad	Cumb	per land,	111D 21502
	Registr		APR 15	2005	S. p.	Goods.				

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			For State Registrar	State of Mar		artment of F rtificate of I			2005	12012
			Registrar     Decedent's Name (First, Middle, I	ast)	00	rincate or	Dealli	2. Date of Death	3. No. 9 0 0	3. Time of Death
	Physicia /Medic Examin	al		izabeth Ba	artles	4b. City, Town, o	r Location of Death	ACY L	Day H Year 4c. County of Deat	3 4:10pm
	Examin		Washington (		oital	Нас	gerstow	n	Washing	ton County
	Funeral Director		5. Social Security Number 6		(In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 1	(ear) 9. Birt	hplace (State or Foreign buntry)
			220-52-1519 Usual Residence of Decedent		30			March 2	20 1947 A	<del>Maryland</del>
	urylan show		10a. State 10b. County	1	10c. City, Town or Lo	ocation				10d. Inside City Limits
	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If Item 27 is merked other then "natural", or Items 23a or 28s-f show or other treumatic svent. The Mcdical Examinar must be notified at	Director	Maryland Was	hington	Smith	sburg 10f. Zip Code		100	g. Citizen of What Co	1 ☐ Yes 2M No
	3a or		12912 Still	Mondow Bos	, a		702			
	death	Funerai	11. Marital Status	12. Was Decedent Ev Armed Forces?	er in U.S. 13.	Was Decedent of H	7.8.3 lispanic Origin? (S	pecify Yes or No-	Inited St	lates Incan Indian,
9	after or ite	Ē	1 Never Married 2 Married			If Yes, specify Cuba 1 ☐ Yes 2 ☐ No	Specify:	o nican, etc.)	Black, White	
003	ural',	d by	3 ☐ Widowed 4 ☐ Wivorced	Year or Dates:					Specify:Whi	
21215-0036	in 72 in 72	Completed	15. Decedent's (Specify only highest	grade completed)	(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of wor	rking	6b. Kind of Business/	Industry
212	e filed withing Hygiene. other than yent, the M	E O	Elementary/Secondary (0-12)	College (1-4or 5+)		stomer s	Service	Attd R	etail Est:	ablishment
pu	al Hygi al Other vent, I	BeC	17. Father's Name (First, Middle, La					ne (First, Middle, Ma		LOTE STREET
ylaı	2 should be and Mental Is marked o	10	John S. Christo	pherson			Margare	et E. Mil.	ler	
Maryland	2 short and and less in the mercent resumers		19a. Informant's Name/Relationship			5976			City or Town, State, 2	
	1 and 2 Health sem 27		Robert E. Bart	es (Son)	12520 20b. Place of Dispo	O Bradbur	y_AveS		Maryland oc. Location - City or	
nor	nt of I		1X Burial 2 ☐ Cremation 3		20b. Place of Dispo cemetery, cre	matory or other place wn Mem Pa		-	agerstown	
Baltimore,	permit. Peges 1 Department of H Importent: If Ite any Injury or ot once.		<ul><li>4 □ Donation 5 □ Other (Spe</li><li>21. Senature of Funeral Service Lin</li></ul>		1					
Ba	Depermine Deperm		1) Jaurla	Al Xin	1.	331 Facto	Doi	uglas A. I	Fiery Func	eral Home Land 21742
			23a. Part1. Enter the disease, or co shock, or heart ailure. List or	omplications that caused the	ne death. Do not en	ter the mode of dyir	ng, such as cardiad	or respiratory arres	stown Mary	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	2	umonia					Onset and Death
R	/Medical		resulting in death)	Due to (or as a	consequence of):					00(44)
п	Examiner		Sequentially list conditions,	b. Lun	2 Conc.	e-				
	ed sit	Examiner	if any, feading to infriedrate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence of):					
	sicien and burial-transit	xan	that initiated events resulting in death) Last	c. Due to (or as a	consequence of):					
760	le be executed ysicien and e burial-transit	cai		d						
68	eath certificate attending phy for use as the	Medi	is service 1							
Вох	th cer tendir r use	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of 1 ☐ Live birth 2		□Ectopic pregnancy	,		23d. Date of del	,
П	The law requires that the death certifical tie has been signed by the attending phy bage 2 should be detached for use as the	Physician/Medi	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4□Pregnant at tii 9□Unknown		Other (specify)	1	,	Month	Day Year
Δ.	res that the de signed by the a be detached f		Part II. Other significant condition	s contributing to death but	not resulting in the u	underlying cause giv	en in Part I.	23e. Did toba	cco use contribute to	the cause of death?
ds,	uires r sign lid be	d by	Corona	ing Arter	n Diseas	4		y <b>X</b> Yes	2 □ No 3 □ Pr	obably 4 Unknown
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Re	The lay	mo						autopsy performs	ed? death?	completion of cause of
ital		BeC	25. Was case referred to medical examiner?				26. Place of Dea	ath (Check only one)		2010
of V	S S	To	1 ☐ Yes 2 No	Hospital: 1 Anpatient	2 ER/Outpatie		4   Nursing F	lome 5 Residen	ce 6 □Other (Spec	cify)
		iuo]	27. Manner of Death 1 ∠ Natural 5 □ Pending	28a. Date of Injury (Month, Day)	Year) 28b. Time o	Wor		28d. Describe how	injury occurred	
isio	ttend death stor: /	icat	2 ☐ Accident investiga 3 ☐ Suicide 6 ☐ Could no	t be	y - At home, farm, st		Yes 2 □ No	28f Location /Stro	et and Number or Ru	red Payto Number
Division	To the Hospitel or Attending P within 24 hours after death.  To the Funeral Director: After t completely filled in by the funeral	Certification:	4 ☐ Homicide determin	building, etc.		reet, ractory, office		City or Town,		irai Noute Number,
	ospite hours ineral		29a. Certifier 1 Certifying	Physician: To the best of	my knowledge, dea	th occurred at the tir	me, date and place	, and due to the cau	se(s) and manner as	stated.
	the Ho in 24 the Fu	Medical	(Check only 2 Medical Ex	caminer: On the basis of e and manner state	examination and/or in ed.	nvestigation, in my o	pinion, death occu	irred at the time, dat	e and place, and due	to the cause(s)
	To t	Σ	29b. Signature and title of certifier	17		29c. Licens			d. Date signed (Monti	
•			Wille	15/Cem	2		8471	4	1/13/05	
\ A	H-7		30. Name and address of person w	2 7 G / I	ath (Item 23a) (Type	Print)	4. 1	1.1	hd 2178	¥ 2
	Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar	Signature	) 15W7X	1 my	soury!	hd 2/18	) _>
	Regist		APR 1	5 2005 Jane	Signature	perter				
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		1	For Amend Item 26tater of Mary 1823, 05	<b>Pagy <sub>የ</sub>ያኒስታ</b> Health and M e <i>rtificate of Death</i>		ene g. No.O A A S	13013
			Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death
	Physicia /Medic		Martin Dale BUSSARD		April 9,	2005 Year	2:55 PM
	Examin		4a. Facility Name (If not institution, give street and number) 17418 Shepherdstown Pike	4b. City, Town, or Location of Death Sharpsburg		4c. County of Death Washingt	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda 2 ☐ F 6.2 Yrs.		8. Date of Birth March 12	9. Birth (2017) 1943 Mar	place (State or Foreign intry) Yland
	and		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or	Location			10d. Inside City Limits
	Maryi -f sho	tor	Maryland Washington Sharps	ourg			1X Yes 2 □ No
	with the 3e or 28e	I Direc	10e. Street and Number 309 West Chapline Street	10f. Zip Code 21782	10	g. Citizen of What Col	untry?
920	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. item 27 Is marked other than "netural", or Items 23e or 28e-f show other traumatic evant, the Medical Examinations must be notified at	by Funeral Director	11. Marital Status  1 ☐ Never Married  3 ☐ Widowed 4 ☑ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	3. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. Race · Ame Black, White Specify: Wh	
21215-0036	n 72 ho "netur edical l	Completed	(Specify only highest grade completed) (G	cedent's Usual Occupation ive kind of work done during most of work b. DO NOT use retired)	king	6b. Kind of Business/l	ndustry
212	12 should be filed within hand Mental Hygiene. 7 Is marked othar than " traumatic evant, the Mer	Somp	Elementary/Secondary (0-12)   College (1-4or 5+)	aborer		block com	pany
and	be file ntal Hy ad oth evant	Be	17. Father's Name (First, Middle, Last)  Martin Clifford Bussard	18. Mother's Nam	ne (First, Middle, M Juanit	<sub>(aiden Sumame)</sub> a Faith	
Maryland	should nd Mer marke imatic	은		ailing Address (Street and Number or Rui			lip Code)
	1 and 2 : Health ar tem 27 Is			North Hall Street,	12 to 12 to		
Baltimore,	Page nent o		1 ABurial 2 Cremation 3 Hemoval from State  4 Donation 5 Other (Specify)  Cedar La	awn Memorial Apr	il 13, 2005 H	agerstown,	Maryland
Balt	pernit. Pa Depurtmen Importent: any injury once.		- IT MAN III III INDINING -	415 East Wilson Blv	d., Hage		2.0
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any leading to immediate.  Due to for as a consequence of:	enter the mode of dying, such as cardiac	or respiratory arre	SE <sub>p</sub>	Approximate Interval Between Onset and Death
0,	cate be executed obysician and the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (ocas a consequence of):  C. Due to (ocas a consequence of):	Edwal &	Tee	d -	Gruenth
8760	phys the	dical	d. Concern				Ormival
O. Box 6	he death certific the attending p ched for use as	Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3 Ectopic pregnancy 5 Other (specify)		23d. Date of deli Month	ivery Day Year
ds, P.	requires that the de een signed by the a hould be detached	by	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.	23e. Did tob	acco use contribute to s 2 □ No 3 □ Pr	
Record	law as b 2 s	completed			24a. Was ar autops perform 1 Yes 2	v / prior to d	topsy findings available completion of cause of
Vital	ysician: The is certificate he director, page	Be C	25. Was case referred to medical examiner?		th (Check only one	8)	a:
o	ting Ph n. After th funeral	ည	1 Yes 2 No Hospital: 1 Inpatient 2 EP/Outpart  27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 2 Accident investigation	e of 28c. Injury at	ome 3 Reside 28d. Describe ho	nce 6 <b>X</b> Other (Spec w injury occurred	Sister's Home
Division	To tha Hospital or Attending Ph within 24 hours after death. To tha Funeral Diractor: After th completely filled in by the funeral	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury · At home, farm building, etc. (Specify)	, street, factory, office	28f. Location (St. City or Town	reet and Number or Ru , State)	ural Route Number,
£3	a Hospital or 24 hours afte Funeral Dir etely filled in	Medical C	29a. Certifler (Check only one)  1 Certifying Physician: To the best of my knowledge, control one)  2 Medical Examiner: On the basis of examination and/or and manner stated	leath occurred at the time, date and place or investigation, in my opinion, death occu	e, and due to the ca arred at the time, da	ause(s) and manner as ate and place, and due	stated. to the cause(s)
	To tha within 2 To tha complet	Me	29b. Signature and title of certifier	29c. License number	25	9d. Date signed (Month	h, Day, Year)
			30. Name and address of person who completed cause of death (Item 23a) (Ty	rpe. Print)		47KIL 11 2	000
9	H-7		19414C Leitersburg Pike	· Hagerstown	1, Mid	21743	2
	St Regist	ate rar	31. Date filed (Month, Day, Year)  32. Registrár's Signature	Sperths			

			1 - State Registrar	e of Maryland	/ Depa	artment of H <i>tificate of L</i>	ealth and Me D <i>eath</i>	ental Hygie: Reg.	him W C/ S	13914
	Physici	an	1. Decedent's Name (First, Middle, Last)					2. Date of Death	Day Year	3. Time of Death
	/Medic	al	James L. Cl		•			APRIL 6	, 2005	1546 P <sup>M</sup>
	Examin	er	4a. Facility Name (If not institution, give street an PRINCE GEORGES HOSPIT			4b. City, Fown, or CHEVERLY	Location of Death		4c. County of Dea PRINCE GI	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. las	t birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		thplace (State or Foreign
	Director		577-72-9439 1XM 2	52	Yrs.	Months Days	Hours Min.	(Month, Day, Ye Apr. 5, 1	953 Was	sh.D.C.
	and ow		Usual Residence of Decedent  10a. State 10b. County	10c. City,	Town or Lo	cation				10d. Inside City Limits
	Many First	tor	D.C.		Was	hington				1 ☐Yes 2 ☐ No
	th the	Director	10e. Street and Number			10f. Zip Code		10g.	Citizen of What Co	ountry?
	ath wi	rai	2433 Shannon PLa				020		U.S.A.	
36	72 hours after death with the Maryland 'natural', or itams 23e or 28e-f show dical Evand et must be rodiffed at	by Funerai	1 Never Married 2 Married 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Decedent Ever in U.S. of Forces?  /es 2 No s, Give		Vas Decedent of His f Yes, specify Cubar I □ Yes 2★ No	spanic Origin? (Spec n, Mexican, Puerto R Specify:	ify Yes or No- ican, etc.)	14. Race - Ame Black, Whit	e, etc.
9	2 hour	ted t	15. Decedent's Education	or Dates:	16a. Deced	lent's Usual Occupa	ation	16b	. Kind of Business	ack Industry
215	thin 7: e. an "n	Completed	(Specify only highest grade completed in the complete state of the	ge (1-4or 5+)			luring most of working	9		,
2	led wii lygien har th	Con	11		A	uditor			Amtrak	RR
Maryland 21215-0036	ntal H ad ott	) Be	17. Father's Name (First, Middle, Last)  James L. Clyb	urn Sr		1 2 3	18. Mother's Name			
Ž	shouk nd Me mark matic	<sup>2</sup>	19a. Informant's Name/Relationship (Type, Print		19b. Mailin	g Address (Street a	nd Number or Rural	Louise Route Number. Cit		
	alth al		Roberta Clyburn	Wife			n PL.S.E			
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is merked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Eventrating be indiffied at once.		20a. Method of Disposition  1 ★ Burial 2 □ Cremation 3 □ Removal  4 □ Donation 5 □ Other (Specify)	from State 20b. Plac	e of Disponence Nat	sition (Name of natory or other place 1 Mem . Pa	ark Apr	.14,05	Location - City or Laurel	
Balt	permit. Departrimports any inji		21. Signature of Funeral Service Licensee	mt	9	. Name and Addres 08 Kenne	s of Facility Hun edy St.N	t Funer	al Home	011
			23a. Part1. Enter the disease, or complications to shock, or heart failure. List only one cause	hat caused the death. on each line.	Do not ente	er the mode of dying	g, such as cardiac or	respiratory arrest,		Approximate Interval Between
	Priysician	5 1	Immediate Cause (Final disease or condition resulting in death)	rultiple 1	aru	nes				Onset and Death
	/Medical- Examiner		Du Du	e to (or as a consequer	nce-hf);					
Ų,		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	e to (or as a conseque	nce of):					
	acuted ind transii	Examiner	that initiated events c.							
68760,	ificate be exacuted g physician and as the burial-transit	cai E)	d d	e to (or as a consequer	nce of):					
	= 2,40	Aedicai	IF FEMALE:							
.O. Box	that the death cert ed by the attendin detached for use	by Physician/M	23b. Was decedent pregnant in the past 12 months?	s, outcome of pregnanc .ive birth2	eath 3	Ectopic pregnancy Other (specify)			23d. Date of del Month	ivery Day Year
s, P.	that I	y Ph	Part II. Other significant conditions contributing	to death but not resulti	ng in the ur	nderlying cause give	n in Part I.	23e. Did tobacc	o use contribute to	the cause of death?
ords	w requires to been signs should be							1 ☐ Yes	2 No 3 □ Pr	obably 4 Unknown
Vital Record	Physician: The law requires that the rthis certificate has been signed by the rail director, paga 2 should be detache	Completed						24a. Was an autopsy performed	prior to death?	topsy findings available completion of cause of
/ita	cian: ertifica	Be	25. Was case referred to medical examiner?				26. Place of Death	-	7	
of \	Physician: this certific ral director,	P .	_	1 Inpatient 2 EF			4 U Nursing Home	5 Residence		cify)
On	ding h. After tuner	tion	1 Natural 5 Pending	Month, Day Year)	3.02	28c. Injury Work	at ? ′es 2.⊠No ₽	d. Describe how in		by sport
Division	Attending If death. actor: After by the fune	ifica	3 Suicide 6 Could not be determined 28e.1	Place of Injury - At home				f. Location (Street	and Number or Ru	ral Route Number,
Ö	tal or s afte al Dira ed in b	Certification;	4     Homicide	ouilding, etc. (Specify)	(way		1	City or Town, St.	495 off	The MI
	Hospital 24 hours a Funaral I	edical	29a. Certifier (Check only 1 ☐ Certifying Physician: T (Check only 2 ☑ Medical Examiner: On	o the best of my knowle he basis of examination	edge, death	occurred at the time	e, date and place, an	d due to the cause	(s) and manner as	stated. to the cause(s)
	To the Hospital or Attending Phwitin 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Med	one) and 29b. Signature and title of certifier	manner stated.		29c. License			Date signed (Month	
	F 3 F 8		la 1 Man	nin		OCME				,
0	(2)		30. Name and address of person who completed	cause of death (Item 2	3a) (Type, i					2005
	-6/		Tasha Z Greens	era M.D.		111 Pe	nn Street	Baltimor	e, Maryl	and 21201
**	Sta Registr		31. Date filed (Month, Day, Year) APR 1 1 2005	32. Registrar's Signatur	hou	E				

			State of Manyland / Den	eartment of Health and Mental I				
			101	ertificate of Death	2005 12016			
			Decedent's Name (First, Middle, Last)	2. Date of				
	Physici /Medio		ISABELLE M. CORMIER	Apr				
	Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death			
			Prince George's Hospital	Cheverly	Prince George's			
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	Months Days Hours Min. 8. Date of (Month)	Birth 9. Birthplace (State or Foreign Country) 5, 1920 New York			
	Director		106-16-4478 84 Yrs.  Usuel Residence of Decedent	July	5, 1920 New 10FK			
	nylan thow		10a, State 10b. County 10c. City, Town or b	coation	10d. Inside City Limits			
	8a-f s	cto	MD Prince George's Cheverly		1 ☐ Yes 2X No			
	with the	Funeral Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?			
	eath	erai	5813 Dewey Street  11. Marital Status   12. Was Decedent Ever in U.S.   13	20785 Was Decedent of Hispanic Origin? (Specify Ves or	USA  No- 14. Race - American Indian,			
တ	or Iten	F	Armed Forces?  1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🛣 No	. Was Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc.	Black, White, etc.			
215-0036	within 72 hours after death with the Maryland ene. than "natural", or iteme 23s or 28s-f show he Madical Examiner riust be roullied at	d by	3 ☐ Widowed 4 🏋 Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2X No Specify:	Specify: White			
<u>5</u>	natu	Completed	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Given	edent's Usual Occupation e kind of work done during most of working DO NOT use retired)	16b. Kind of Business/Industry			
212	withir ene. than	d m	Elementary/Secondary (0-12) College (1-4or 5+)	enographer	Federal Government			
	filed with Hygiene other thai	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Mid				
'lan	Mental Mental arked c	To B	Jiacomo Massar	Louise Busca	ni			
Maryland	is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mantal Hyglene. Item 27 is marked other than "natural", or iteme 23s or 28s-1 show other treumatic event, the Madical Examiner must be required at	ľ	19a. Informant's Name/Relationship (Type, Print) 19b. Mai	ling Address (Street and Number or Rural Route Nu	ımber, City or Town, State, Zip Code)			
	1 and Health em 27 Ither tr			antern Hill Road, Queen	4			
Baltimore,	Pages 1 nent of H int: If Ite		T LI Burial 2 X Cremation 3 Li Hemoval from State	ematory or other place)	20c. Location - City or Town, State			
ij				can Crematory 4/11/2005	Alexandria, Virginia			
Ba	permit. Departr Import any Inj				•			
			23a. Part1. Enter the disease, or complications that caused the death. Do not en		ry arrest. Approximate			
1	Physician		shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  A Due to (or as a consequence of):	endreme	Onset and Death			
	/Medical		resulting in death)  Due to (or as a consequence of):	271 - 17 - 17 - 17 - 17 - 17 - 17 - 17 -	13441			
0	Examiner		sequentially list conditions, b. Moltiple in	traabdominal / Polvie	Absesser Days			
	ted sit	nine	Se quentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	0	9.4.46			
,	te be executed ysicisn and e burial-transit	Examine	that initiated events resulting in death) Last C. Due to (or as a consequence of):	ratisaty leve	9249			
760,		cai	d. Small	bourd obstruct	DAYS			
89	ntifica ng ph s as th	Medi	IFFEMALE:					
Вох	ath ce ttendi or use	Physician/Med	23b. Was decedent pregnant in the past 12 months?	☐Ectopic pregnancy	23d. Date of delivery			
0.	he de the a	ysic	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 9 ☐ Unknown 5	Other (specify)				
۵.	The law requires that the death certifica tie has been signed by the attending ph page 2 should be detached for use as it		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I. 23e. [	Did tobacco use contribute to the cause of death?			
Records,	w requires been sign should be	ed by	Respurtou failup	1	Yes 2 No 3 Probably 4 Unknown			
oce	law requ as been 2 should	Completed	Entero cutomen fift		Vas an 24b. Were autopsy findings available			
- B	The ate h	Com	Ileastony Colaston		erformed? death?			
Vital	Physicien: this certific ral director.	Be	25. Was case referred to medical examiner?	26. Place of Death (Check of	nly one)			
of	Phys this cral dir	. To	1 ☐ Yes 2 No rospital. 1 Appatient 2 ☐ ER/Outpatient 2. ☐ Manner of Death 28a. Date of Injury 28b. Time		Residence 6 Other (Specify)			
on	ding th. : After fune	tlon	1 Natural 5 Pending (Month, Day Year) Injury 2 Accident investigation	Work?  M 1 Yes 2 No	now injury occurred			
Division	Attending r death.	Ifica	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, s	street, factory, office 28f. Location	on (Street and Number or Rural Route Number,			
Ö	s afte	Cert	4 Homicide building, etc. (Specify)	City or	T OWΠ, State)			
	Hospl 4 hour Funer ely fill	ical	29a. Certifier (Check only (Ch	ath occurred at the time, date and place, and due to investigation, in my opinion, death occurred at the time.	the cause(s) and manner as stated. ne, date and place, and due to the cause(s)			
	To the Hospitel or Attending Physicien: The law within 24 hours after death.  To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	Medical Certification:	one) and manner stated.  29b. Signature and title of certifier	29c. License number				
	F ₹ ₹ 8		& Michael Trans	00052865				
2	(10)		30. Name and address of person who completed cause of death (Item 23a) (Type		I pre le			
	(0)		K. Michael Figaro MD 3001 Hospita	l Drive, Cheverly, Mary	land_20785			
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature	•				
	Regist	rar	APR 1 2 2005		attsville, Maryland  Approximate Interval Between Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset on			

		For State Registrar	State of Maryland	d / Depa		n and M	lental Hygie		1391
Physici		1. Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day Year	~
/Medic Examin		Reese George C  4a. Facility Name (If not institution, give s			4b. City, Town, or Location	on of Death	April	10 2005 4c. County of Dec	
		6213 Sudlersvi	lle Road		Sudlersvi			Queer	n Anne's
Funeral Director		5. Social Security Number  212-56-2291  Usuel Residence of Decedent	7. Age (In yrs. la		If Under 1 Year If Und Months Days Hour		8. Date of Birth (Month, Day, Y		rthplace (State or Fore ountry) DE
death with the Maryland rms 23e or 28e-f show r must ke notified at	ctor	10a. State 10b. County  MD Queen A		Town or Local lersv					10d. Inside City Lim 1 ☐ Yes 24☐
vith th	Director	10e. Street and Number			10f. Zip Code		100	. Citizen of What C	ountry?
8 23e	ral	6213 Sudlersvi	. 11e Road 12. Was Decedent Ever in U.S	2 42 14	21668	0-1-1-2 /5-	acity VariatiNa	USA 14. Race - Am	agaa ladiaa
urs after de ai', or item Examiner	by Funeral	11. Marital Status  1 Never Married 212 Married  3 Widowed 4 Divorced	Amed Forces?  1 Yes 2 XNo If Yes, Give Year or Dates:		/as Decedent of Hispanic Yes, specify Cuban, Mexi ☐ Yes 2 \( \overline{\text{V}} \) No \( Specify \)		Rican, etc.)	Black, Whi	
be filed within 72 hours after death with the Marylan tall Hygiene.  Ad other than "natural; or items 23s or 28s-1 show event, the Maxical Examiner must be nutities at	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+)	(Give I	ent's Usual Occupation aind of work done during m O NOT use retired)	nost of work	ing 16	b. Kind of Business	/Industry
Hygier Hygier Other th	ပ်	11		Tru	ck Driver	-45 - 4 - B1	- /5' 14'	Cement	
ntal H	Be	17. Father's Name (First, Middle, Last) William Robert	Carpontor		18. MC		e (First, Middle, Ma er Cook	iden Sumame)	
snould be and Mental smarked o	ဥ	19a. Informant's Name/Relationship (Ty)		19b. Mailine	Address (Street and Nun			City or Town, State.	Zip Code)
27 is		Catherine Carp		1	3 Sudlersv				
of Health item 27 other tr		20a. Method of Disposition	20b. Pl	ace of Dispos	ition (Name of atory or other place)			c. Location - City or	
artment or ortant: If injury or		1 XBurial 2 ☐ Cremation 3 ☐ R 14 ☐ Donation 5 ☐ Other (Specify)	emoval from State		rsville	4/1	4/2005	Sudlers	sville
permit. Pages Department of It Important: If ite any injury or ot		21. Signature of Juneral Service License	Fellows	22.	Name and Address of Fa Fellows, H 370 W Cypr	delfe ess	nbein & St Mill:	Newnam	Funeral
Physician /Medical Examiner	er	23a Fart. Enter the disease, or complishock, or hear allure. List only or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, any, basing to missage cause. Enter Underlying Cause (Disease or injury	(	ience of):					interval Between Onset and Death
eatir certificate be executed attending physician and for use as the burial-transit	dical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequ	ence of):					
ite has been signed by the attending phi bage 2 should be detached for use as th	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnar 1 Live birth 2 Fetal 4 Pregnant at time of de 9 Unknown	death 3 1	Ectopic pregnancy Other (specify)			23d. Date of de Month	olivery Day Year
in signed by the a	ed by Pt	Part II. Other significant conditions cor	tributing to death but not resu	Iting in the un	derlying cause given in Pa	irt I.	23e. Did tobac		o the cause of death?
	Complet						24a. Was an autopsy performe 1 □ Yes 2 □	prior to death?	utopsy findings availa completion of cause
certificate rector, pag	Be (	25. Was case referred to medical examiner?				ace of Deat	h (Check only one)		
r this certific	ို	1 Yes 2 No		ER/Outpatient			me 5 Residence		ocify)
fler death. Director: Aftein by the fune	Certification:	Matural   5   Pending	28a. Date of Injury (Month, Day Year)  28e. Place of Injury - At hor building, etc. (Specify,	Injury me, farm, stre	28c. Injury at Work?  M 1 □ Yes 2  et, factory, office	□No	28d. Describe how 28f. Location (Stree City or Town, S	et and Number or R	ural Route Number,
within 24 hours a To the Funeral C	edical Ce	29a. Certifier (Check only one)  (Check only one)	sician: To the best of my know har: On the basis of examinati and manner stated.	vledge, death ion and/or inve	occurred at the time, date estigation, in my opinion, d	and place, death occurr	and due to the caused at the time, date	se(s) and manner a and place, and du	s stated. e to the cause(s)
within To th compl	Me	29b. Signature and title of certifier	n m	9	29c. License numbe		29d	Date signed (Mont	th, Day, Year)
		30. Name and address of person who co	mpleted cause of death (Item	23a) (Type, F	Print)		MD 21	. [(2,0	
Sta Registr		31. Date filed (Month, Day, Year) APR 1 2	32. Registar's Signate	ure	Bartle				

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day **JACK** CUNNINGHAM /Medical April 5, 2005 1:35 P 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death College View Nursing Home Frederick Frederick If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, Year 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral**  Birthplace (State or Foreign
Country) 1☑M 2□F Director 232-26-7373 83 16, 1921 West Virginia Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f show traumatic event, the Medical Examiner must be notified at Maryland Frederick Brunswick Directo 1 ☐Yes 2 ☐ No 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ò 408 East D, St. or iteme 23a 21716 United States death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Pages 1 and 2 should be filed within 72 hours atter onent of Health and Mental Hygiene. Sont: If item 27 Is marked other than "naturel", or ite 1 ☑ Yes 2 ☐ No
If Yes, Give
Year or Dates: WW II 1 Never Married 20 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No δ Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Electrician U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be .Iohn Cunningham Alice ပ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Importent: If Item 27 Is any injury or other trait once. Roxanne 207 East K. St./ Brunswick, Maryland Falconer / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State \* 4 □ Donation 5 □ Other (Specify) Frederick Crematory |04/08/2005 | Frederick, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 23a. Part 1. Exer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock of heart failure. List only one cause on each line. 1100 N. Maple Ave./ Brunswick, Maryland 21716 Approximate Interval Between Onset and Death END-STAGE **Physician** RENAL DISEASE disease or condition resulting in death) YETHES /Medical Due to (or as a consequence of) Examiner MELLITUS YEMPS DIABETES Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) To the Hospitel or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Day 4☐ Pregnant at time of death 5 ☐ Other (specify) P.O. 1 signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Be Completed by CEREBAM cate hes been sign, page 2 should b UKSCUCKR ACCIDENT 2 No 1 🗆 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Certification: To 1 ☐ Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3□ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending 24 hours after death.
Funerel Director: A investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 1116675 cause of death (Item 23a) (Type, Print) 30. Name and address of person who complete SHINE MUGATER RUNSGICK 31. Date filed (Month (17) (North) 8 strar's Signature Registrar

**Physician** /Medical Examiner

Physician

/Medical

**Examiner** 

Director

Funeral

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Completed

Be

**Funeral** 

Director

item 27 is marked other than "natural", or items 23a or 28a-1 show other traumatic event, the Madical Examinar must be motified at

of Health and Mental Hygie item 27 is marked other

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked oth any injury or other traumatic event ADRS.

Baltimore, Maryland 21215-0036

use as the burial-transit the attending physician and signed by

Examiner by Physician/Medical Completed Be Certification: To

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attanding Phyaician: The law requires that the death certificate be executed this After t hours after death 24 hours a within 2

WIL

LANSING MICHAEL 31. Date filed (Month, Day, Year) State

25. Was case referred to medical examiner?

5 Pending

investigation

6 Could not be determined

1 ☐ Yes 2 ☐ √o

Manner of Death

1 Natural

2 Accident

3 Suicide

4 Homicide

(Check only one)

29b. Signature and title of certifier

Hospital: 1 Inpatient

28a. Date of Injury (Month, Day Year)

29c. License number D42827

1 Yes 2 No

28c. Injury at Work?

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) APRIL 4, 2005

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Yes

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

26. Place of Death (Check only one)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD

DR., SUITE 14 OWING MILLS, MD 21117 20 CROSSMONS

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

32. Registrar's Signature APR 0 6 2005

Registrar DHMH 17 Rev 1/2001

Medical

2 ER/Outpatient 3 DOA

28b. Time of

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death April **Physician** 12, Day 2005 Delores Jean Custer 4:00 PM /Medical 4b. City, Town, or Location of Death 4a Fecility Name (If not institution, give street and number) 4c. County of Deeth Examiner 2167 Aarons Run Road Westernport Garrett 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🛛 F 215-44-9145 Maryland Director Usual Residence of Decedent permit. Peges 1 and 2 should be filed within 72 hours effer deeth with the Meryland Depertment of Heelth and Merital Hygiene. Important; if Itam 27 is marked other than "natural." 10c. City, Town or Location 10e. State 10b. County 10d. Inside City Limits MD. Garrett Westernport 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2167 Aarons Road Run 21562 United States Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 □ Never Married 25DkMarried 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Specify: White 1 Yes 2⊠No Specify: 2 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Construction Laborer 12 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Hugh R. Miller Olive Mayhew 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paul Custer Sr./ husband 2167 Marons Run Road, Westernport, Maryland 21562 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 04/15/ 200. Location - City or Town, State Frostburg, Maryland 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Frostburg Memorial Park 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility Boal Funeral Home 21. Signature of Funeral Service Licensee Wan 111 Church St., Westernport, Maryland 21562 2 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician OVARIAN CARCINOMA

Due to (or es a consequence of): /Medical Immediate Cause (Final disease or condition resulting in death) month Examiner Examiner or Attanding Physicisn: The lew requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or es a consequence of) Physician/Medical P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 thinknown Records, <u>۾</u> 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was en autopsy performed? 1 Tyes 1 ☐ Yes 2 ☐ No Division of Vital Be 25. Wes case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑No Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Natural 5 Pending 1 ☐ Yes 2 ☐ No deeth. investigation 2 Accident 6 ☐ Could not be determined 3 Suicide To the Hospital or Atta within 24 hours effer de To the Funeral Directo completely filled in by ti 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier to Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) APRIL 13 2005 126907 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cumberland, Md. 21502 Dr. Harjit Sidhu 925 Bishop Walsh Rd., 31. Date filed (Month, Day, Year) 32. Registrar's Signature State APR 1 4 2005 Registrar DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

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			Registrar  1. Decedent's Name (First, Middle, La	st)			inicati	01 2	Jean	-	2. Date of [		VO.		3. Time of Death	_
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	Funeral		Social Security Number     6. S	6ex 7. Agu I□M 21XIF		last birthday)	If Under Months	1 Year Days	If Under :	24 Hrs Min.	8. Date of E (Month,	Birth Day, Yea	ar)	9. Birt	hplace (State or Foreign ountry)	7
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	r 28e	Funeral Director	10e. Street and Number				10f. Zip	Code				10g. (	Citizen	of What Co	ountry?	
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	r dee	Jue .	11. Marital Status	12. Was Decedent I Armed Forces?		S. 13.	Was Deced	ient of Hi	ispanic Orig In, Mexican	gin? (Spe , Puerto	ecify Yes or I Rican, etc.)	No-		Race - Ame Black, White	encan Indian, e, etc.	
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Maryland 21215-0036	within 72 hours after deeth with the Maryland ene. then "naturet", or items 23s or 28e-f show the Medical Examinat must be notified at	ed b	15. Decedent's E	ducation		16a. Deced	dent's Usua	al Occupa	ation		_	16b.	Kind o	Whi of Business/		_
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Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturet," or items 23s or 28e-f show any injury or other treumatic event, the Medical Examinet must be notified at ODGs.		21. Signature of Funeral Service-Lice	7	101 6						orne f					_
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			1 - For Registrar	State o	f Maryland			Health and I			005	13921
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	/Medi Exami	cal	Mildred Irene 4a. Facility Name (If not institution		nber)		4h City Town	or Location of Death	April	11, 20		8:35 pm <sup>™</sup>
	Exami	iei	Reeders Memori				Boons		•			
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. la	ast birthday)	If Under 1 Year Months Days	If Under 24 Hrs.	8. Date of Bi	rth	shing 9. Bjrt	ton hplace (State or Foreign untry)
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ume: (	permit. Pages 1 and Department of Heali Important: If itam 2 any injury or other once.		20a. Method of Disposition 1 X Burial 2 ☐ Cremation		20b. Pla	ace of Dispo	sition (Name of natory or other pla	4	Date		on - City or T	
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	e des the at	slcl	1 Yes 2 No 9 Unknown	4☐Pregna 9☐Unkno	ant at time of dea		Other (specify)	·			Month	Day Year
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Division of Vital Becords.	Attending Physician: r death. actor: After this certifica		27. Manner of Death	28a. Date o	·	28b. Time of	28c. Injur		28d. Describe I			19)
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Q	ital or irs afte rai Dira											
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical	29a. Certifier (Check only one) Certifying 2 Medical S	Physician: To the xeminer: On the ba and mann	sis of examination	ledge, death on and/or inv	occurred at the tin estigation, in my o	ne, date and place, pinion, death occur	and due to the red at the time,	cause(s) and date and plac	manner as se, and due t	stated. to the cause(s)
	ro the vithin o the	Me	29b. Signature and title of continer	and maill	7		29c. Licens	e number		29d. Date sig	ned (Month.	Day, Year)
	- s - ō		12	TIM			DUL	996				2005
			30. Name and address of person w				Print)					
0	4-5		Dr. Zafar Malik					MD 21713	301-4	32-847	0	
	Sta		31. Date filed (Month, Dav. Year)	32 Be	oistrar's Signatu	re						
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State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death Month Day **Physician** BERNARD RAY CLAYTOR 9:30A M April 8 2005 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Ocean City Worcester 113 135th St., Lot 134 If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Months 1 **X**M 2 □ F Director Aug.10,1932 72 223-36-2176 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show other traumatic avant, the Medical Examiner must be notified at Ocean City 1x Yes 2 □ No MD Worcester Completed by Funeral Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 113 135th St., Lot 134 21842 US Itams 23a filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 XYes 2 □ No After
If Yes, Give
Year or Dates: |-3|-55 1 Never Married 2 Married ō Specify: White Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 Divorced 'natural', 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other than " College (1-4or 5+) Elementary/Secondary (0-12) Restaurant 12 Supervisor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 12 should be fil h and Mental H ' Is marked oth Be Arnold Price Claytor Olive Lillian Davis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) itam 27 1005 Turnberry Lane, Southlake, Texas 76092 Deborah Frazier 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 0 = 6 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Important: If any injury or once. Cape Henlopen Crem. 4-II-05 Frankford, DE ervice Licensee 22. Name and Address of Facility The Burbage Funeral Home 108 William St., Berlin, Md. 21811 Mutale 23a. Part1. Enter the disease, or complications that clused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of chiline. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cardo vascela 11000 rest Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Completed by Physician/Medical Examiner The law requires that the death certificate be executed burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year ō in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 4☐Pregnant at time of death P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. 1 Yes 2 No 3 Probably 4 Hocknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 1 🗆 Yes Division of Vital To the Hospital or Attanding Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 100 Other: 4 Nursing Home 5 Residence 6 □Other (Specify) Certification: To 1 🗌 Yes 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 1 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To tha Funaral L 1 Cartifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
20 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 05 1209 completed cause of death (Item 23a) (Type, Print) Doodelle Pegistrar's Signature 31. Date filed (Monta Year) State Registrar

	-	For State Registrar		;	State o	of Ma	ryland		irtment of tificate of				gienę Reg. Nd:	7 11 1	15	13923
Physicia		1. Decedent's Name (	(First, Middle,		м. с	ianc	i					2. Date of Dea Month	Day	2005	Year	3. Time of Death
/Medica Examine		4a. Facility Name (If n	ot institution,	, give str	reet and nu	ımbər)			4b. City, Town,	or Location	of Death	ДРИ		County o	f Death	1120
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Funeral Director		5. Social Security Nur 196-01-171		6. Sex 1 🗆 N	u 2□ <b>X</b> F	-	(In yrs. la	ast birthday) Yrs.	If Under 1 Year Months Days		24 Hrs. Min.	8. Date of Birt (Month, Da April I	h y, Year) <b>B, 19</b> 1	5	9. Birthp Coun NY	lace (State or Foreign try)
pug *	-	Usual Residence of D	ecedent 10b. County				10c. City	, Town or Lo	cation						11	Od. Inside City Limits
Maryla f sho	ō	DE	_	usse	×				Beach							1 XYes 2 □ No
1 the 1	ect	10e. Street and Numb	овг						10f. Zip Code				10g. Citi	zen of Wi	nat Coun	try?
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IOFE, INICIVIZITIES A. I. A. I. S. I	by Funeral Director	11. Marital Status 1 ☐ Never Married 3 ☑ Widowed 4			2. Was Dec Armed Fo 1 Tes If Yes, Gi Year or D	orces? 2 <b>⊠</b> No ive		l l	Vas Decedent of Yes, specify Cul	ban, Mexicai	n, Puerto	ecify Yes or No Rican, etc.)			- Americ , White, o	
2 hou	ted	1	5. Decedent'	's Educa	tion			16a. Deced	ent's Usual Occu	pation	et of work	ring	16b. Ki	nd of Bus	iness/Inc	dustry
thin 7	Completed	Elementary/Second	only highesi dary (0-12)	grade	College (		-)	life. L	OO NOT use retir	ed)	SE OF WORK	arig				
led will lygien her th		8		15				Seam	stress	1000	- d- No	- 151 161-01-				ments
VIAITO uld be fil Mental H nrked ott	To Be	17. Father's Name (F										e (First, Middle, erite To			,	
Mary d 2 sho lith and 27 is mu		19a. Informant's Nam <b>Judith</b>			e, Print)				g Address (Stree							Code)
of Hea	-	20a. Method of Dispo		2 DB0	moval from	State	20b. Pl	lace of Disportant	sition (Name of natory or other pla	ace)		Date	20c. Lo	cation - C	ity or To	wn, State
Dallimor Permit. Pages Department of mportent: If It iny injury or o		`4 □ Donation 5				21819	Ital		nerican					anto	-	
Dalkimore, in permit. Pages 1 and Department of Healt Importent: If Item 2 any injury or other 200ce.		21. Signature of Tune	ara/Service L	Licenses	ule	ile_			. Name and Addr 08 Willia						eral	Home
		23a. Part1. Enter les shock, or he it	Asease, A d failure. List o	complica only one	ations that cause of	used to	the death	. Do not ente	er the mode of dy	ing, such as	cardiac	or respiratory ar	rest,			Approximate Interval Between Onset and Death
Physician		Immediate Cause (Fi disease or condition resulting in death)	inal	a.	M-	etw	3111	TL B	nest a	A						Oriset and Death
/Medical Examiner	-	1000ting in doutin			Due to	(or as a	consequ	uence of):								
	Je.	Sequentially list conditions if any, leading to imm	nediate	b.	Due to	(or as a	consequ	uence of):								
cuted nd ransit	Examin	cause. Enter Underly Cause (Disease of in that initiated events		c.												
6 / OU, sate be executed hysicien and the buriat-transit		resulting in death) La	st		Due to	(or as a	consequ	uence of):								
	dicai			d.												
BOX of Boath certification attending for use as	Physician/Me	IF FEMALE: 23b. Was decedent p in the past 12 m 1 ☐ Yes 2 0 9 ☐ Unknown	onths? No	230	o. If yes, ou 1□Live 4□Preg 9□Unkr	birth 2 nant at t	Fetal	death 3	Ectopic pregnand Other (specify)	су				23d. Date Mont		ry Day Year
that the ed by detac	h Ph	Part II. Other signific	ant conditio	ns contr	ibuting to c	death but	t not resu	alting in the ur	nderlying cause g	iven in Part I	l.	23e. Did to	obacco u	se contrib	ute to th	e cause of death?
	d by											1 🗆 Y	'es 2[	□No 3	Prob	ably 4 Unknown
law rec	Completed											24a. Was		24b. W	ere autop	sy findings available
VICAL MEC sicien: The law certificate has b irector, page 2 s	E O											autop perfor	rmed? 2 <b>X</b> No	de	ath?	npletion of cause of
VITAL icien: Sertifica ector, p	BeC	25. Was case referre examiner?	d to medical							26. Place	of Deat	h (Check only o				73
Or VITA Physicien: rthis certific ral director,	0	1 ☐ Yes 2 ▼N	0	Ho		Inpatien		ER/Outpatien	t 3□ DOA O	ther: 4 🗆 Nu	ursing Ho	ome 5 Resid	lence (	5 □Other	(Specify	)
ding Phys	ü.	27. Manner of Death 1 Natural	5 Pending		28a. Date (Mor	of Injury	Year)	28b. Time of Injury		ork?		28d. Describe h	ow injur	y occurred	d	
ttend death stor: /	cat	2 Accident 3 Suicide	investig	not be	28e Place	e of Injur	n, At ho	imo farm etr	M 1 [	Yes 2	No	28f Location (9	Street an	d Number	or Rura	Route Number,
UIVISION  I or Attending after death. Director: After d in by the fune	Certification;	4 Homicide	determi	ined	build	ling, etc.	(Specify	/)	et, factory, office	,		City or Tox			OI ITUITAI	rioute Number,
	Medical C	29a. Certifier 1 (Check only one)	Certifying Medical E	g Physic Examine	r: On the b	e best of chasis of chasis	examinat	wledge, death tion and/or inv	occurred at the restigation, in my	time, date ar opinion, dea	nd place, ath occur	and due to the ored at the time,	cause(s) date and	and mani place, ar	ner as sta	ated. the cause(s)
To the Mithin To the	Me	29b. Signature and ti	tle of certifier						29c. Licer	nse number			29d. Dat	e signed	(Month, L	Day, Year)
		Mol	her	Ma	Jusu	)			Hi	1013	214		4	4/11	100	
11 20		30. Name and addre	of person v	who com	pleted cau	ise of de	ath (Item	23а) (Туре,				-		1		
H, 10		Jeff	_	nm			31	Fres	tun M	ح کم	iti	JOL B	nci	CW C	31	811
Stat Registra	1 2	31. Date filed (Month	PR 1	200		gistra	r's Signal	ture	med ?							

					yland / Dep		lealth and N	Mental Hygi	2000	13021
	0	50	Decedent's Name (First, Middle, Last)					2. Date of Death	1	3. Time of Death
	Physici /Medic		JACQUEL	INE BELL	E DA	NFORTH		April		4:30 A M
	Examin		4a. Facility Name (If not institution, give si	reet and number)		4b. City, Town, o	r Location of Death		4c. County of Dea	ath
			Frederick Memor						Reg. No.  Date of Death Month Day Pril 7, 2005  4c. County of Deat Freder  Date of Birth (Month, Day, Year) Agy 12, 1930  Pen  10g. Citizen of What Co UNited St  Yes or No- an, etc.)  14. Race - Ame Black, Whith Specify:  16b. Kind of Business/ Own Ho irst, Middle, Maiden Sumame) rbin oute Number, City or Town, State, 2 t, MD 21788  7, CVICES, Skkot Coc Vy. Frederick, Trederick, Spiratory arrest,  23d. Date of del Month  23e. Did tobacco use contribute to 1 27e. Spiratory arrest,  23d. Date of del Month  23e. Did tobacco use contribute to 1 29c. Location - City or Spiratory arrest,  24b. Were au performed? 1 Yes 2 No 3 Pr  24a. Was an autopsy performed? 1 Yes 2 No 3 Pr  24b. Were au performed? 1 Yes 2 No 3 Pr  24b. Were au performed? 1 Yes 2 No 3 Pr  24c. Cocation (Street and Number or Ru City or Town, State)  due to the cause(s) and manner as at the time, date and place, and due  29d Date signed (Month)  due to the cause(s) and manner as at the time, date and place, and due  29d Date signed (Month)  due to the cause(s) and manner as at the time, date and place, and due	
	Funeral		5. Social Security Number 6. Sex			Months Days	Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Bi	rthplace (State or Foreign country)
	Director		102-24-0010		74 113.			May 12,	1930 Per	nnsylvania
	/land		10a. State 10b. County		IOc. City, Town or I	ocation				10d. Inside City Limits
	Man a-f sh	tor	Maryland Frederick		Thurn	ont				1 ☑ Yes 2 ☐ No
	or 28	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What C	ountry?
	23a	ral	3 Sandy Spring Cour	t, Apt. 6						
	tems tems	Funeral	The Market States	Armed Forces?	er in U.S. 13	. Was Decedent of h If Yes, specify Cub	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)		
36	rs aft	by F	1 ☐ Never Married 2 ☐ Married 3 🕱 Widowed 4 ☐ Divorced	If Yes, Give		1 ☐ Yes 2 🖾 No	Specify:		Specify:	White
9	72 hours after death with the Maryland natural; or Items 23a or 28a-f show disal Examinat must be Inditied at	led !	15. Decedent's Educ	ation	16a. Dec	edent's Usual Occup	pation	.     1	6b. Kind of Busines:	s/Industry
215	within 7: ene. than "n	pie			(Giv	e kind of work done DO NOT use retire	during most of work d)	ang		
21	filed with Hygiene. other than	Completed	Substant   Certificate of Death   Certificate of Death   Certificate of De		ome					
nd	0 - 0 %	Be						, ,	faiden Sumame)	
<u>\</u>	2 should be and Mental le marked of eumatic eve	မ			10h Ma	Can Address (Charac			City on Town State	Zin Cordo)
Maryland 21215-0036										Zip Code)
	s 1 and 3 if Health item 27 other tr				20b. Place of Disi	osition (Name of				r Town, State
JOE	9°= 5			moval from State		-	1 -		rederick,	Maryland
Baltimore,	orte inj			е						
Ö	Department Department		1/11/1		5	501 Catoo	tin Mtn.	Hwy. Fre	derick, M	D 21701
			23a. Part1 The Inv disease, or mplic sircle, or heart failure. List only on	ations that caused the cause on each line	ne death. Do not e	nter the mode of dyi	ng, such as cardiac	or respiratory arre	st,	Approximate Interval Between
	Physician		disease or condition	Pne	umani	d				Onset and Death  F Day 5
	/Medical Examiner		resulting in death)	Du to (or as a	consequence of):	.) N=				/
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	ted nsit	in in	cause. Enter Underlying							
Ć,	te be executed ysician and te burial-transit	Examiner	resulting in death) Last	Due to (or as a	consequence of):					
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9	death certificat attending phy I for use as the	Medi	IE EEMALE:							1
Вох	ath ce tendi	an/	23b. Was decedent pregnant		Fetal death 3		y			Day Year
-	the a	Physician/Med	1 ☐ Yes 2 Z No		me of death 5	Other (specify)			_	,
P.0	that the de led by the detached			tributing to death but	not resulting in the	underlying cause giv	ven in Part I.	23e. Did tob	acco use contribute	to the cause of death?
Records,	uires sign ld be	d by	Cerebravasa	Max	548014	e		1	s 2 2 No 3 □ F	Probably 4 Unknown
CO	w requir been si should	iete						24a. Was ar	1 24b. Were a	utopsy findings available
Re	sicien: The law requires that the death certifical certificate has been signed by the attending phirector, page 2 should be detached for use as it	Completed	- Micerce John E	<i>X</i> ()	1_T1_1_(	7.GEV		perform	ied?   death?	
Vital		Be C					26. Place of Dea			3 2010
Į V	Physicien: this certific ral director.	To E		ospital:	2 ER/Outpati	ent 3 DOA Ott	ner: 4 🗆 Nursing H	ome 5 Reside	nce 6 Other (Sp.	ecify)
n of	ding Ph			28a. Date of Injury (Month, Day		of 28c. Inju- Wo	ry at rk?			
Sio	tendi leath. tor: A the fu	cati	2 Accident investigation	20 01 111			Yes 2 □ No	204 Leasting /Cta		Dent Davida Mambas
Division	or At after of Direct in by	Certification;	dataminad	building, etc.	y - At nome, farm, : (Specify)	street, factory, office				tural Houte Number,
	spitel ours a nerel (	Ce	29a Certifier 1 Certifying Phys	ician: To the best of	my knowledge, de	ath occurred at the ti	me, date and place.	and due to the ca	use(s) and manner a	s stated.
	24 h	Medical	(Check only 2 Madical Examin	er: On the basis of e	xamination and/or	investigation, in my	opinion, death occur	red at the time, da	ite and place, and du	e to the cause(s)
	To the Hospitel or Attending within 24 hours after death.  To the Funerel Director: After completely filled in by the funer	Me	29b. Signalure and title of certifier			29c. Licens	se number	29	d. Date signed (Mor	th, Day, Year)
			- X	hah ,	Hirch	no -	5764	3	41710:	
			30. Name and address of person who con	mpleted cause of dea	ath (Item 23a) (Typ	a, Print)	-		4	54 E
	.,		65 c Thai	nas	Thons	cas Ob	tre	deno	15 MD	1702
**	Sta Regist	ate rar	APR 0 8 20	005	w B	Charles				

			1 - For State Registrar	State of Ma		id / Depa	artment	of He	alth a	•	lygie	ene	05	1392	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
	Physici	ian		•					-			Day or	Year	3. Time of Death	-
					Sr.		4h Cih, T	own or l	continu of		4,		. of D#	/:50 p. M	1
	Examir	ier			tal					Death					
	Funeral		Social Security Number 6. 5	Sex 7. Age		last birthday)	If Under 1	Year	If Under 2		Birth				n
Physician (Post, Mother, Law) Thomas Walter De Vaughn, Sr.  Thomas February Review for endough gas user are changed programs of the control o	ork														
	and and	State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decembers have first. Model, Last) 2. Date of Death Thomas Walter De Vaughn, Sr.  2. Date of Death April 4. Selective have right or shattened you were and members Frederick Memorial Hospital 5. Seath Service Wemorial Hospital 7. Prederick Memorial Hospital 7. Prederick Wemorial Hospital 7. Prederick Prederick 7. Service were and members Frederick Memorial Hospital 7. Prederick 8. Seath Service Wemorial Hospital 9. Seath Service Wemorial Hospital 9. Seath Service Wemorial Hospital 9. Seath Service Wemorial Hospital 9. Seath Service Wemorial Hospital 9. Seath Service Wemorial Hospital 9. Seath Service Wemorial Hospital 9. Seath Service Wemorial Hospital 9. Seath Service Wemorial Hospital 9. Seath Seat		Orl Inside City Limits	_										
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	th the	irec	10e. Street and Number				10f. Zip C	ode			10g	. Citizen of	What Cour	itry?	_
	ath wi	rai	7322 Ridge Roa	d.			21	702				U.S.A	١.		
	er dea itams	nue		Armed Forces?		.S. 13. \	Was Deceder f Yes, specify	nt of Hisp y Cuban,	anic Orig Mexican,	in? (Specify Yes or Puerto Rican, etc.)	No-				
36	irs aft	by F		If Yes, Give	10		1□Yes 2□	No	Specify:			Specif	y: <b>W</b>	hite	
Ö	72 hou	ted	15. Decedent's E	ducation		16a. Deced	dent's Usual (	Occupation	on		16	b. Kind of B			
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22	iled w Hygier thar th	S	17 Father's Name (First Middle Last			Print	ter		0.34-4	- N (Fine Adid		_			_
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3	shoul nd Me mark	Ĕ		-		19b. Mailin	g Address (S				ber, C	ity or Town.	State. Zip	Code)	_
2	and 2 alth a 27 is er trai		Barbara Sellers -	The printing seed and numbary in the printing seed of the printing seed seed of the printing seed of the printing seed of the printing											
ore	of He of He if item or oth			Removal from State	20b. P	lace of Disposemetery, crem	sition (Name	of er place)			200	c. Location	City or To	wn, State	-
Ě	Pag ment tant: I		*4 ☐ Donation 5 ☐ Other (Special	y)	Mt.	01ivet	Ceme	tery	4-	-8-2005	Fre	deric	k, Ma	ryland	
Bail	Depar Mpor Mny in		21. Signature of Funeral Service Lice	isee .	1										
State of Maryland / Department of Health and Mental Hygleine  Certificate of Death  Ros No. 2 0 0 5  Ros No. 2 0 0 0 5  Ros No. 2 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0					2										
F.	/Medical Examiner	icai	disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Listed or Injury that initiated events	b	consequ	uence of):								Onset and Death	
	ertific ding pl	/Med	IF FEMALE:	22a If was autooms										73	
		ysician	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 4 ☐ Pregnant at	2 🗌 Fetal	death 3								•	
٦.	that the by detact		Part II. Other significant conditions of	ontributing to death bu	t not resu	ılting in the un	derlying caus	sa given i	in Part I.	23e. Dio	tobac	co use cont	ribute to the	a cause of death?	
Sp	quires n sigr uld be									1	] Yes	2 🗆 No	3 Proba	ibly 4 Dunknown	
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<u> [a</u>	cian: ertific ector,	0	25. Was case referred to medical examiner?							f Death (Check only	one)				_
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0	ding h. After funer	tion	1 Vilatural 5 Pending		Year)			Work?			how i	njury occurr	ed		
	Atten r deat sctor: by the	ifica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Inju	ry - At hor	me, farm, stre			2 0100		(Stree	t and Numb	er or Rural	Route Number	-
5	al or	Serti	4   Homicide	building, etc.	(Specify	)	, ,,-			City or To	own, S	tate)			
	he Hospit in 24 hour ha Funara sletely fills		Chock only Z   Medical Exali	urier: On the basis of	examınatı	vledge, death ion and/or inve	occurred at t estigation, in	the time, my opini	date and j on, death	place, and due to the occurred at the time	e cause , date	e(s) and ma and place, a	nner as sta and due to	ted. the cause(s)	
	To ti withi To ti comp		29b. Signature and title of certifier	0								_	(Month, D	ay, Year)	
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	10		Kusay Barakat					t, ]	Frede	rick, Mar	yla	nd 2	1701		
	Sta Registra	-	31. Date filed (Month, Apr Year) 8	2005 32. Refistrat	's Signat	ure	mak!	,							

State of Maryland / Department of Health and Mental Hygiene For State Registrar Amend Item #5 per INF G851 1 Post 106 at Hof Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) April 8, 2005 11:40 P M **Physician** LAVERNE DULL LLOYD /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Prince George's Prince George's Hospital Cheverly | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year May 18, 1 Birthplace (State or Foreign Country) 6. Sex 1 M 2 ☐ F 7. Age (In yrs. last birthday) 5. Social Security Name **Funeral** Yrs. Missouri 83 498-12-<del>3304</del> Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County rightlied at 1 Yes 2 No Hyattsville Director Maryland | Prince George's 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ral', or items 23a or Examiner must be 20781 US 5704 Hamilton Street Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

V☐ Yes 2 ☐ No

If Yes, Give Year or Dates: WW I I 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married X Married 1 Yes 2 XNo Specify: Baltimore, Maryland 21215-0036 Specify: White þ 3 Widowed 4 Divorced "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry of Health and Mental Hygiene. Itam 27 is marked other than "natur other traumatic event, the Musical Elementary/Secondary (0-12) College (1-4or 5+) Newspapers Circulation Manager 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Edna Agnes Goodrich Harry Trimble Dull 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5704 Hamilton Street, Hyattsville, MD 20781 Betty G. Dull - Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If its any injury or ot ance. 1 Burial 2 Cremation 3 Removal from State Trinity Memorial Gdns:4-12-05 Waldorf, MD \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Huntt Funeral Home P. O. Box 156, Waldorf, MD 20604 21. Signatur of Funeral Service Licensee M00053 Stephson Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death CARDIAC Immediate Cause (Final disease or condition resulting in death) ARRHYTHMIA FATAL Physician /Medical Due to (or as a consequence of): ARTERY DISEASE **Examiner** CORONARY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner ARRHYTHMIA To the Hospital or Attending Physicien: The law requires that the death certificate be executed attending physician and for use as the burial-transit CARDIAC Due to (or as a consequence of) Box 68760. Be Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months?
1 Yes 2 No 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. 1 ate has been signed by the a page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, BYPASS GRAFT ARTERY 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕱 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of After Injury 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. investigation 2 Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 4 Homicide TEX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 152865 ast at 30. Name and address of person completed cause of death (Item 23a) (Type, Print) CHEVERLY MD 20785 3001 FIGARO HOSFITAL MICHAEL 31. Date filed (Month, Day, Year) 32. Resstrar's Signature State APR 1 2 2005 Registrar

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			1 - For State	State of	f Marylan					and Me	ental Hy	giene	nn	Fine	1200	7
			Registrar			Cel	rtificate	e or L	Jeani			Reg. No:	. 0 0	U	1072	
	Physici	an	Decedent's Name (First, Middle, Land)								2. Date of De Month	Day		Year	3. Time of Death	
	/Media	cal	Gordon Samuel Da								pril 4		05		4:05 P	.VI
4	Examir	ier	4a. Facility Name (If not institution, gi						Location o	f Death			County o			
			Westminster Nurs  5. Social Security Number  6.		nab Cen 7. Age (In yrs.		West If Under		If Under 2	24 Hrs.	8. Date of Bir		rrol		and (Chair and Court	
и	Funeral Director		214-12-1446	1X M 2□F	82	Yrs.	Months	Days	Hours	Min.	(Month, Da	y, Year) 192	22 M	Count [ary]	ace (State or Forei	gn
			Usual Residence of Decedent		02					2	iug. /	, 174	-2 1.	aryı	and	-
	yland how		10a. State 10b. County		10c. Cit	y, Town or Lo	cation							1	Od. Inside City Limit	is
	a-f	Funeral Director	MD Carroll		Mt.	Airy									1 □Yes 2 N	10
	or 28	Olre	10e. Street and Number				10f. Zip					10g. Citi	izen of WI	nat Coun	try?	
	23a	ral	2209 Flag Marsh	Road			217						ed S	tate	S	
	tams rer	une	11. Marital Status	Armed For		.S. 13.	Was Deced If Yes, spec	ent of His	spanic Orig n, Mexican	gin? (Spec , Puerto F	cify Yes or No Rican, etc.)	)-	14. Race Black	<ul> <li>Americ</li> <li>White,</li> </ul>		
36	s afte	y F	1 ☐ Never Married 2 🕅 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes If Yes, Giv Year or Da	е		1 ☐ Yes 2	No 🛣	Specify:				Specify:	T.Th. 4	+ 0	
8	be filed within 72 hours after death with the Maryland that Hygiene. Id other than "natural", or Itams 23a or 28a-f show event, I're Medicel Ever in the medical Ever in the medical expensions.	Completed by	15. Decedent's 8			16a. Dece	dent's Usua	I Occupa	tion			16b Ki	ind of Bus	Whi		
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212	filed with Hygiene. Ither ther	mo	Elementary/Secondary (0-12)	College (1	-4or 5+)	Forem	ıan					MD	Stat	e De	pt Transp	٠.
b	e filed Il Hygie other vant, Il	Be C	17. Father's Name (First, Middle, Las	t)			-		18. Mothe	r's Name	(First, Middle	, Maiden	Sumame	)	•	
<u>a</u>	should be nd Mental markad o	ToE	Samuel George Da	vis					Rosa	Ruth	Woodw	ard				
Maryland 21215-0036	2 should be and Mental is marked c		19a. Informant's Name/Relationship	(Type, Print)		19b. Mailir	ng Address	(Street a	nd Numbe	r or Rural	Route Numb	er, City o	r Town, S	tate, Zip	Code)	
	is 1 and 2 should of Health and Meritem 27 is marks other traumatic		Myra Davis	Wif			Flag			ad M	ít. Air	у, М	D 2	1771		
ore			20a. Method of Disposition 1 X Burial 2 □ Cremation 3 I	□Removal from :	State 20b. P	lace of Dispo emetery, crer	sition (Nam natory or of	ne of Ther place	e)	Da April	ate Q	20c. Lo	cation - C	ity or To	wn, State	
Ë	nit. Pages artment of l ortant: If its injury or of		`4 onation 5 Other (Spec			. Olive	e Ceme	etery	7   4	200		Mt.	Airy	, Ma	ryland	
Baltimore,	permit. Page Department of Important: If eny injury or once.		21. Fign Jure of Funeral Service Lice	11111		22 F	. Name and	d Address	s of Facility	y Funer	al Hom	e &	Crem	ator	v. P.A.	
	~ C = • 0		X/MM//)	aug							al Hom Road		fiel	d, M		
			a. Part f. Enter the disease, or cor shock, or heart failure. List only	one cause on e	aused the deat ach line.	n. Do not ent	er the mode	e of dying	, such as	cardiac or	respiratory a	rrest,			Approximate Interval Between Onset and Death	
	Physician		Imm ate Cause (Final diseast or condition resulting in death)	- of Me	tasta hic	: Par	ادرود	hic	Car	cino	Ms					
	/Medical Examiner	1		Due to (	or as a conseq	uence of):										
		-e	Sequentially list conditions,	b. Due to (	or as a nonsag	uenna of):								-		-
	uted J ansit	듄	Sequentially list conditions, any leading of in reciate cause. Enter Underlying Cause (Disease or injury that initiated events													
Ć	te be executed ysician and ie burial-transit	Examiner	resulting in death) Last	c. Due to (	or as a conseq	uence of):										
760,	ž × 6	cal		_ d.												
99	leath certificate b attending physic for use as the b	Med	IF FEMALE:													
Вох	th ce tendi	an/I	23b. Was decedent pregnant in the past 12 months?	23c. If yes, out 1☐Live bi	come of pregna irth 2 🗌 Feta		Ectopic pre	egnancy				1 2	23d. Date Mont		ry Day Year	
0.	at the dea by the a tached fo	Physician/Med	1 Ves 2 No	4□Pregna 9□Unkno	ant at time of down	eath 5	Other (spe	ecity)					WOIL		Day (Gai	
Ω.	that the		Part II. Dther significant conditions	contributing to de	eath but not resi	ulting in the u	nderlying ca	avise aive	n in Part I		23e Did t	obacco u	ise contrib	oute to th	e cause of death?	
Records,	95	d by	Supraventrica	1 .	chycar		i ao i jing oc	3170			10			Prob		/n
ÿ	w requir been si should	Completed									24a. Was		24b W			_
Rec	The lav	du	Coronas A	(RS	Dise	3.4					autor	osy ormed?	pri	or to con ath?	sy findings availab apletion of cause of	
Vital		C	25. Was case referred to medical						oe Bloss	of Dooth	1 Yes	2.25No	1 [	Yes	2 No	
>	Physician: r this certific ral director,	To B	examiner? 1 ☐ Yes 2 No	Hospital:	npatient 2	ER/Outpatien	it 3□ DO	Otho	C		(Check only only only only only only only only		S □Other	(Specific	· · · · · · · · · · · · · · · · · · ·	
ı of	g Ph er thi		27. Manner of Death	28a. Date o		28b. Time of		Bc. Injury Work	at		8d. Describe					
Ö	Attending P death. ctor: After y the funer	atlo	1 Accident 5 Pending investigation	on	n, Day rear)	Injury	М		es 2□N	No						
Division	tal or Attendii s after death. al Diractor: A ad in by the fu	Certification:	3 Suicide 6 Could not determined	1 286. Place	of Injury - At ho	ome, farm, str	eet, factory,	, office		28	8f. Location (3 City or Tox			or Rurai	Route Number,	
	ital o irs aft rel Di															
	To the Hospital or Attending within 24 hours after death.  To the Funarel Director: After completely filled in by the fune	edical	(Check only 2 Medical Exa	hysician: To the iminer: On the ba	sis of examina	wiedge, death	n occurred a vestigation,	at the time in my op	e, date and inion, deat	d place, ar	nd due to the d at the time,	cause(s) date and	and man	ner as sta	ated. the cause(s)	
	thin 2 tha mple	Med	one) 29b. Signature and title of certifier	and mann	ner stated.			License					e signed			
			Bald	ma. =					393	2 0		U	1 1	05	-wy, roury	
•	Mar		30. Name and address of person who	completed carre	e of death /lter	23a) (Type		, ,	- 12	) (		( )			21157	
	4		Babak Iman		O 412	•	lce/m	Do	V4 :	Suite	304	was	itmin	ster	MD	•
	Sta	ate	31. Date filed (Month, Day, Year)	32. Re	egir rar's Signa	ture									1 2	
	Registi	rar	APR 0 7	2005	Clave	K	Cool	م								

State of Maryland / Department of Health and Mental Hygiene 2 0 0 5 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Helen Fay DAVIES 10, 2005 April 2:48 pm /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Reeders Memorial Home Boonsboro Washington If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Feb. 15,1914 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 105-01-7452 New York Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 77 is marked other than "natural", or Itams 23a or 28a-f show traumatic event, the Medical Examinat must be notified at 1 ☐ Yes 2 No Be Completed by Funeral Director Maryland Washington Keedysville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21756 USA 6503 Coffman Farms Road 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: white 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) ges 1 and 2 should be filed with of Health and Mental Hygiene. If item 27 is marked other there homemaker her own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) George Gallanger Nellie Fay Hanes 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Marcia Davies - daughter 6503 Coffman Farms Dr., Keedysville, Md. 21756 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages permit. Pages Department of Important: If it any injury or o 1 ☐ Burial 2 A Cremation 3 ☐ Removal from State Hagerstown Crematory 4/12/05 Hagerstown, Maryland \* 4 □Donation 5 □ Other (Specify) 22 Name and Address of Facility 21. Signature of Funeral Service Licensee MINNICH FUNERAL HOME Kunnel 115 E. Wilson Blvd., Hagerstown, Md. 21740 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Alpheimeis discare Immediate Cause (Final **Physician** Charco disease or condition resulting in death) /Medical as a consequence of): **Examiner** Sequentially list conditions, if any, leauing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner signed by the attending physicien and deed be detached for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Donknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has b autopsy moneo 1 ☐ Yes 2 ☐ No 21 No 1 Yes the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Uursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 After thi funeral 27. Manner eath 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 1 tural 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death. To the Funeral Director; A Accident filled in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 90062223 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21740 301-739-7100 340 Mills St., Hagerstown, MD 3H-4 Dr. Praveen Bolarum 31. Date filed (Month, Day, Year) 32. Registrar's Signature State APR 1 2 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

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Mary

altimore,

Box 68760,

P.0.

of Vital Records,

Division

Vame:

		1 - For State Registrar	State of Mai	ryland / Depa	artment of Hertificate of L	ealth and M Death			U5	13929
Physic	cian	Decedent's Name (First, Middle, Las.		-			2. Date of De Month	ath Day	Year_	3. Time of Death
/Med		William Stoke		Jr.			4	06	05	9:00 A
Exam	iner	4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Death				
		5. Social Security Number 6. Se	al Nedical	(In vrs. last hirthday)	If Under 1 Year	If Under 24 Hrs.	8 Date of Bird	I W		2 ace (State or Forei
Funera Directo			AM 2□E	## Ac. County of Dear Ac. County	Count	ry)				
		Usual Residence of Decedent					2/2/13	722	Mary	Tand
rylan		10a. State 10b. County		10c. City, Town or Lo	cation				10	d. Inside City Limi
Ba-1 s	cto	Maryland Worces	ter	Pocomoke	City					1X Yes 2 □ N
or 20	Dire	10e. Street and Number						10g. Citizen	of What Count	ry?
ath w	ra Fa	19 Central Ave.								
should be filed within 72 hours after death with the Maryland nd Mantal Hygiene. marked other than "natural", or Items 23a or 28a-f show imatic event. It a Madical Examinating the notified at	Funeral Director	11. Marital Status	Armed Forces?		Was Decedent of His f Yes, specify Cubar	spanic Origin? (Sp. n, Mexican, Puerto	ecify Yes or No Rican, etc.)		Race - America Black, White, e	
rs aft	by F	1 ☐ Never Married 2 ★ Married 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give A	rmy	1 ☐ Yes 2X No	Specify:		Spe	ecity: wh:	ite
tura	ed	15. Decedent's Edi		16a, Dece	ent's Usual Occupa	tion		16b Kind o	of Rusiness/Ind	ustry
nin 72 n n	Completed	(Specify only highest grad	de completed)	(Give	kind of work done di	uring most of work	ing			,
filed within Hygiene. Sther than ent. It e M	E	12	College (1-401 5+	1	ager			Pro	duction	l
be file ital Hyg id othe event.	BeC	17. Father's Name (First, Middle, Last)				18. Mother's Name	e (First, Middle,	Maiden Sun	name)	
should be ind Mental is marked o	10	William Stokely D	oix Sr,			Marjori	le Cust	is		
~ ~ ~		19a. Informant's Name/Relationship (T	ype, Print)		-			-		Code)
of Health of Health item 27 i		Doris Dix/wife								
ges 1 t of H If ite or otl		20a. Method of Disposition  1 Burial 2 X Cremation 3 Di	Removal from State	cemetery, crer	sition (Name of natory or other place		Date	20c. Location	on - City or Tov	vn, State
Pactment tant:		'4 □Donation 5 □ Other (Specify,					2005	Salis	bury, N	1D
permit. Pages 1 a Department of Hee Important: If item any injury or othe		21. Signature of Fundral Service Licens	Dean	He	olloway Me	elson Fur	neral Ho ocomoke	me P.A	A. MD 218	51
		23a. Part1. Enter the disease, or comp shock, or heart failure. List only	lications that caused the	he death. Do not ent						Approximate Interval Between
Physiciar		Immediate Cause (Final disease or condition	For	unonia						Onset and Death
/Medica		resulting in death)							*	
CXAIIIIIE	١.	Sequentially list conditions,	b							
ed sit	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence of):						
cate be executed physician and the burial-transit	Examin	that initiated events resulting in death) Last	cDue to (or as a	consequence of):						
be e sician buria	a E			,-						
ficate physics the	edical	-	d							->=ZZ
The law requires that the death certific te has been signed by the attending p oage 2 should be detached for use as	N/Me	IF FEMALE: 23b. Was decedent pregnant						23d.	Date of deliver	v
death e atte d for	Physician/M	in the past 12 months?	4☐ Pregnant at tie							Day Year
that the de the by the a detached t	hys	9 Unknown	9□ Unknown							
es tha igned be det	by P		ntributing to death but	not resulting in the u	nderlying cause giver	n in Part I.	23e. Did to	obacco use c	ontribute to the	cause of death?
w require been sig should b	ed	CHF, ASCVD					1 🗆 Y	res 2 □ No	3 ☐ Proba	bly 4 Unknow
e law requ has been je 2 shoul	ompleted								b. Were autop	sy findings availab
The late has page	E					-	perfo	rmed?		
ician: The certificate ector, pag	Be C	25. Was case referred to medical examiner?				26. Place of Death				
di is	2	1 ☐ Yes 2 No	Hospital: 1 Anpatient	2 ER/Outpatien	t 3 DOA Other	r: 4 Nursing Ho	me 5 Resid	dence 6 🗆	Other (Specify)	
ling P	on:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day)		Work	?	28d. Describe h	ow injury occ	curred	
Attending r death. ector: After by the fune	Certification:	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be								
l or Attendater death Director:	ıtifi	4 Homicide determined			eet, factory, office				mber or Rural	Route Number,
Hospital or 14 hours afte Funeral Dir tely filled in	edical Ce	29a. Certifier 1 Certifying Phy (Check only 2 Medical Exam	sician: To the best of	my knowledge, death	occurred at the time	e, date and place,	and due to the o	cause(s) and	manner as sta	ted.
	edi	one)	and manner state	ed.						
the hin 24 the F	-	29b. Signature and title of certifier			29c. License	number	1	29d. Date sig	ined (Month, D	ay, Year)
To the Hospital or Attending PP within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	Σ	N 1 0/	/ ~		0 0	10		A . 2		
To the P within 24 To the F complete	2	DA Chris	ushi		02	09/2			7/00	5
To the Ivithin 24 To the F complete	×	DA Chris	ompleted cause of dea	ath (Item 23a) (Type,	Print) Shara	Dr. 3	Mulu		7/00	5

		1 - For State Registrar	State of Marylar		artment of Hertificate of E		lental Hy	/giene/ [] Reg. No.	Ub	13930
Physic /Medi		1. Decedent's Name (First, Middle, Last) Alice Schwien	Evans				2. Date of De Month April		Year	3. Time of Death 8:00 A M
Exami Funeral	ner	4a. Facility Name (If not institution, give 6904 Coolridge I  5. Social Security Number 6. Security Number 15	Drive		4b. City, Town, or Temple  If Under 1 Year  Months Days		8. Date of Bi	4c. County Prince orth ay, Year)	Geor	ge 'S lace (State or Foreign
Director works	J.	Usual Residence of Decedent  10a. State  10b. County	10c. Cit	Yrs.			06-13-	1910	lowa	0d. Inside City Limits
with the M 3a or 28a-f	I Director	MD Prince G  10e. Street and Number  6904 Coolridge D	20192 3	emple	H111S 10f. Zip Code 20748			10g. Citizen of U.S.A.		
filed within 72 hours after death with the Maryland Hygiene. *nature!*, or flems 23s or 28s-f show pht. The Madical Examiner must be notified at	by Funeral		12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates:	1	Was Decedent of His f Yes, specify Cubar 1 ☐ Yes 2 No	panic Origin? (Sp , Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	o- 14. Rad	ce - Americ ck, White, e	
d within 72 h giene. ir than *natu the Medical	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) 12		(Give	dent's Usual Occupa kind of work done di DO NOT use retired) Memaker	ion iring most of work	ing	16b. Kind of B		dustry
should be filled and Mental Hygi marked other umatic event.	To Be C	17. Father's Name (First, Middle, Last)  Otto Christian A  19a. Informant's Name/Relationship (Ty,			g Address (Street a	Selma S	chellen	Maiden Suman berg	пе)	Code
of Health of Hea		Sandra Lyon - Dau  20a. Method of Disposition  1 \( \text{M} \) Burial 2 \( \text{Cremation} \) 3 \( \text{R} \)  3 \( \text{D} \) Other (Specify)	ghter  emoval from State	6104 Place of Disponenterry, crem	McKay Dr sition (Name of natory or other place ction Ceme	. Brand			L3 City or Tov	
permit. Pages 1 ar Department of Hea Important: If Itam 3 any injury or other 9000.		21. Signature of Funeral Service License	1101391	P.	Name and Address Intt Funer 0. Box 1	56, Wald		20604		
Physician /Medical Examiner	dical Examiner	23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence to (or a))).	uence of):	: Heart	Discore	и геориатогу а	11651,		Approximate Interval Between Onset and Death
that the death certificate to the by the attending physis detached for use as the E	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	3c. If yes, outcome of pregna 1 □ Live birth 2 □ Fete 4 □ Pregnant at time of d 9 □ Unknown	death 3	Ectopic pregnancy Other (specify)				le of deliver	TY Day Year
law requires that as been signed b 2 should be deta	by	Part II. Other significant conditions con	tributing to death but not res	ulting in the ur	derlying cause giver	in Part I.		obacco use cont Yes 2 No		e cause of death?
The ate has page	e Completed	25. Was case referred to medical				26. Place of Death	1 ☐ Yes	2 No	Were autoportor to combeath?	sy findings available apletion of cause of 2 No
ttending Phy death. ttor: After this the funeral d	Certification; To B	examiner?  1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined	ospital: 1 Inpatient 2 Inpatient 2 28a. Date of Injury (Month, Day Year)  28e. Place of Injury - At he building, etc. (Specifications)	ER/Outpatient 28b. Time of Injury	28c. Injury a Work?  M 1 70	4 ☐ Nursing Ho	me 5 1 esi 28d. Describe	dence 6 Oth	ed	
Hospital or A 24 hours after of Funeral Director of Fulled in by	Medical Cer	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examir	ician: To the best of my kno er: On the basis of examina and manner stated.	wledge, death tion and/or inv	occurred at the time estigation, in my opi	, date and place, a	and due to the ed at the time,	cause(s) and ma date and place, a	nner as sta	ated. the cause(s)
To the Hi within 24 To the Fi	Me	29b. Signature and title of centier	nely		29c. License			29d. Date signed		
NP 8	ite ar	Dr. William Tann  31. Date filed (Month, Par Year)  APR 1 2 2	er. 11701 Liv	inacto	n Poad #1	01, Ft.	Washing	iton, MD		5 W5

ORIGINAL

GRACIA

5. Social Security Number

220-16-1795

Usual Residence of Decedent

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

1. Decedent's Name (First, Middle, Last)

REGINA

4a. Facility Name (If not institution, give street and number)

RAVENWOOD LUTHERAN VILLAGE

6. Sex

1 ☐ M 2 💢 F

EMMERT

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Yrs.

7. Age (In yrs. last birthday)

Certificate of Death

4b. City, Town, or Location of Death

HAGERSTOWN
If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min.

2005

4c. County of Death

Year

WASHINGTON

9. Birthplace (State or Foreign Country)

MÁRYLAND

10d. Inside City Limits 1⊠Yes 2□No

Approximate Interval Between Onset and Death

Day

Year)

2. Date of Death Month

APRIL 9,

8. Date of Birth (Month, Day, Y)
FEB. 20,

3. Time of Death

		filed within 72 hours after death with the Manylan Hygiene. uther than "natural", or Itame 23a or 28a-1 show ant, the Medical Exampling at	tor	10a. State         10b. County         10c. City, Town or Location         10d								10d. Inside City L		
				MARYLAND WASHINGTON HAGERSTOWN								1 <b>∑</b> Yes 2		
			Director	10e. Street and Number 10f. Zip Code						10g. Citizen of What Country?				
											U.S.A.			
			Funeral	433 S. EDGEWOOD DR. 21740  11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Spec						Specify Yes or No-				
	10		뎚	1 ☐ Never Married 2 🛛 Married	Armed Forces? 1 ☐ Yes 2 ☒ N	3 2 X No		Vas Decedent of Hispanic Origin? (Specify Yes, specify Cuban, Mexican, Puerto Rica Techniques		rto Rican, etc.)		Black, White, etc.		
	33		b	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2X No Specify:				Specify:		WHTTE		
	ŏ		ted	15. Decedent's Education 16a. Decedent's Usual Occupation							16b. Kind of Business/Industry			
	72		ple	(Specity only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  (Give kind of work done during most of working life. DO NOT use retired)						orking			,	
	Maryland 21215-0036		Completed	10	College (1-40) 3	HOMEMAKER					OWN HOME			
	Þ		Bec	17. Father's Name (First, Middle, Last)				1	8. Mother's Na	ame (First, Middle,	Maiden :	Surname)		
	lar		ToE	NEVIN BARNHART					EDNA K	EMP				
	ary	os 1 and 2 of Health a itam 27 la other tra	_	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)										
				LEONARD D. EMMERT/SPOUSE 433 S. EDGEWOOD DR., HAGERSTOWN, MARYLAND 21740										
	ē,			20a. Method of Disposition				on (Name of ory or other place)		Date		ation - City or		
	Ę			1 ⊠ Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specification)					1/1	0./0005	ELEVA T	anono.	364 D375 437D	
	Baltimore,	permit. Page Department of Important: If any injury or once.		21. Signature of Fundal Service V cer		BOONS		EMETERY ame and Address	of Facility	2/2005	d Ma	SBURU,	MARYLAND	
	Ba	permit. Departr Importa any inju		Now VIII		M. Dear		[ FUNERAI		7606 016 Boonsbor				
		Physician /Medical Examiner		23a. Part1. Enter the disease, oceom	olications that caused	the death. Do	not enter th	ne mode of dving	such as cardia			чагутаг		
				23a. Pant. Enter the disease, decomplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Betwee Onset and Dea										
				Immediate Cause (Final disease or condition resulting in death)	a. / 90	une	50	( wood	_					
				<b>1</b>	Due to (or as a consequence of):									
			Ļ	Sequentially list conditions,	b. Jenene demento q									
		ed jis	Examiner	if any, leading to intractiate cause. Enter Underlying Cause (Disease or injury	Direct (or as a consequence of):									
		Physician: The law requires that the derethicate has been signed by the rail director, page 2 should be detached	сап	that initiated events resulting in death) Last	a rungons arrease									
	50,				Due to (or as a	or as a consequence of):								
	87		lca		d	Mwi	7	ris	710-	_				
	9		Me	IF FEMALE:										
acia Regina	Box 68760,		ompleted by Physician/Medical	23b. Was decedent pregnant	23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy					23d. Date of delivery		,		
	E		sici	1 Yes 2 No 4 Pregnant at time of death 5 Other (specify)							Month Day Year			
	Α.		h	9 🗆 Unknown										
	s,		by i	Part II. Other significant conditions of	ontributing to death bu	at not resulting	in the under	tying cause given	in Part I.	23e. Did to	23e. Did tobacco use contribute to the cause of death			
	p		ed	Dengovano						1 🗆 Y	1 Yes 2 No 3 Probably 4 Unkr			
	tal Records, P.O.		plet	1						24a. Was a		24b. Were au	utopsy findings ava	
	æ		E							autops	med?	prior to death?	completion of cause	
ac			O	25. Was case referred to medical				2	6 Place of Do	1 ☐ Yes ath (Check only or	2 No	1 🗆 Yes	No No	
Gr			To B	examiner? 1 ☐ Yes 2 ☐ 10	Hospital:	nt 2□ FB/O	utnationt 3	Cthon				Other (Cae	117. 1 117. 1	
•	of			27. Manner of Death	28a. Date of Injury 28b. Time of 28c. Injury at 28d.				7	5 Residence 6 Other (Specify)  d. Describe how injury occurred				
EMMERT	on		I loi	1 Natural 5 ☐ Pending 2 ☐ Accident investigation		Year)	Injury		s 2 🗆 No		. , ,			
ξ	<u>S</u>		flca	3 ☐ Suicide 6 ☐ Could not be						28f. Location (S	Bf. Location (Street and Number or Rural Route Number,			
豆	Division		Certification:	4 Homicide determined						City or Town	City or Town, State)			
	_	spita ours naraf filled		29a. Certifier 1 Certifying Ph	ysician: To the best of	of my knowledg	e death oo	curred at the time	date and place	e and due to the e	21100(2) -	and macros	ctated	
		24 h	edical	(Check only 2 Medical Exam	niner: On the basis of and manner sta	examination a	nd/or investi	gation, in my opini	on, death occ	urred at the time, d	ate and p	olace, and due	to the cause(s)	
		o the Hos ithin 24 h o tha Fun ompletely	Me	29b. Signature and little of certifier				29c. License n	umber	2	.9d. Date	signed (Monti	h, Day, Year)	

23d. Date of delivery Day Year acco use contribute to the cause of death? 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No ce 6 Other (Specify) eet and Number or Rural Route Number, State) ise(s) and manner as stated

DHMH 17 Rev 1/2001

State Registrar

se of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year 10 FESSLER 7:15 PM ATRICIA JACK PRIC 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. Cify, Town, or Location of Death Examiner 4c. County of Death CHESTERTOWN CHESTERTOWN HUSPITAL CENTER KENT 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) (Month, Day, Year) 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign Country)
NEW YORK. **Funeral** 1□ M 2**X**F 95 22 6543 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits QUEEN ANNES MD Director 1 ☐ Yes 2 No HESTERTUNN Item 27 is marked other than "netural", or items 23a or 28e-f is other traumatic event, the Medical Examinar must be notified 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 220 ROAD 21620 by Funeral U.S.A Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: 3altimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Department of Health and Mental Hygiene, important: If Item 27 is merked other than 'en' lighty or other traumatic event, the Meonce. College (1-4or 5+) Elementary/Secondary (0-12) 12 DIETICIAN 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be BAIRD JACK RUBIAH WILLIAMS JOHN ၉ FRANCES 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) KOBERT 220 FEY Rife

20b. Place of Disposition (Name of cemetery, crematory or other place) RIAD CHESTERTOWN, FESSLER 21620 MD 20a. Method of Disposition
1 ☐ Burial 2 A Cremation 3 ☐ Removal from State 20c. Location - City or Town, State Date CHESAPEAKE CREMATERY 4 ☐ Donation 5 ☐ Other (Specify) CHESTER MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility MARVIN V. WILLIAMS 205 GREEN HEREN WAT CHESTERTOWN, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) CARDIO PULNOVARY ARREST Examiner Examiner ADOLLO CARCINOMA Right lung with MANGRANT

Due to (or as a consequence of): Plevnal Extusis The law requires that the death certificate be executed the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? SICK SINUS Syndronie 1 Yes 2 No 3 □ Probably 4 □ Unknown ð Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en autopsy performed? Filmillation, Rocent Dusertin OF A Persuavent Palenaken, Hypenteusin 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ∏Yes 2 ∏No 2 Accident Director: / 3 Suicide 6 ☐ Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours aft To the Funeral Di completely filled in

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

cause of death (Item 23a) (Type, Print)

32. Re

23889

ARMABACTA. M.D; 223 High Street, Cherkertown Wed 21620

29d. Date signed (Month. Day. Year)

State Registrar

29a. Certifier

29b. Signature and title of certifier

30. Name and address of person wi

31. Date filed (Month,

# Amended Item 1 per M.E. 04/06/2005 Carroll County, wjl Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of M	laryland		artment of H rtificate of L			giene 2	005	13931
- 11	Physici	20	1. Decedent's Name (First, Middle	a, Last)					2. Date of De	ath Day	Year	3. Time of Death
	/Medic		DOWALD L.	ARBER		D L.	FARVER		April	4 10000	2005	1500 P M
	Examin	er	4a. Facility Name (If not institution		)		4b. City, Town, or	Location of Death	1	4c. Cou	nty of Death	
			242 Highmeadow 5. Social Security Number		// /	A for Contract of the	Reister	stown If Under 24 Hrs.			imore	
	Funeral Director		215-48-8146	1 X M 2 F	ge (In yrs. las	Yrs.	Months Days	Hours Min.	8. Date of Bir (Month, Da	y, Year)		place (State or Foreign ntry)
			Usual Residence of Decedent		52	•••			Oct. 7,	1952	Mary.	Land
	how		10a. State 10b. County		10c. City, 1	Fown or Lo	ocation				1	0d. Inside City Limits
	e Mar	cto	MD Balti	more	Reist	erst	own					1 ☐ Yes 2 No
	or 28	Director	10e. Street and Number				10f. Zip Code			10g. Citízen o	of What Cour	ntry?
	ath w	rai	242 Highmeadow	Road			21136			United	State	es
	er de	Funerai	11. Marital Status	12. Was Decedent Armed Forces?	?	13.	Was Decedent of His If Yes, specify Cubar	spanic Origin? (Sp n, Mexican, Puerto	pecify Yes or No Rican, etc.)	- 14. R	lace - Americ lack, White,	
36	rs aft	by F	1 ☐ Never Married 2 ☐ Marr 3 ☐ Widowed 4 ☑ Divorced	If Ves Give	No		1 ☐ Yes 2🏋 No	Specify:		Spec	city	
21215-0036	72 hours after death with the Maryland natural', or Items 23a or 28a-1 show dical Exaction from the notified at	edi	15. Deceden			16a. Dece	dent's Usual Occupa	tion		16h Kind of	Whi Business/In	
15	n "ne	Completed	(Specify only highes	st grade completed)		(Give	kind of work done d DO NOT use retired)	uring most of worl	king	100, Killa ol	Dusiness/in	dustry
212	d within giene. ir than "	E	Elementary/Secondary (0-12)	College (1-4or		llect	ronic Tecl	nnician		MTA		
	al Hyg othe	Be C	17. Father's Name (First, Middle,	Last)				18. Mother's Nam	ne (First, Middle,	Maiden Sum	ame)	
/lai	uid b Ventz irked itic e	5	Guy R. Farver					Margare	t L. Atk	inson		
Maryland	12 should be filed within h and Mental Hygiene. 7 Is marked other than " traumatic event, If a Me.		19a. Informant's Name/Relations	nip (Type, Print)		19b. Maili	ng Address (Street a.	nd Number or Ru	ral Route Numbe	er, City or Tow	m, State, Zip	Code)
≥,	ges 1 and 2 should be filed within 72 hours after death with the Marylan t of Health and Mental Hygiene. If item 27 is marked other than "naturat", or items 23a or 28a-1 show or other traumatic event, If a Medical Examinat man be notified at		Shaun Farver	Son			Highmeador		eisterst	own, M	D 2113	36
ore	of H of H if iten		20a. Method of Disposition 1   ☐ Burial 2 ☐ Cremation	3 ☐Removal from State	20b. Plac	e of Dispo etery, crei	sition (Name of matory or other place	Anri	Date .1 7,	20c. Location	n - City or To	wn, State
Ë	ment mant: lury c		`4 ☐Donation 5 ☐ Other (S	pecify)		an Ch	apel Ch C	em. 200		Woodbi	ne, M	
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any injury or other trat		21. Signature of Funeral Service	My		В	Name and Address urrier-Que 212 W. Old	een Fune:	ral Home	e & Cre	matory	y, P.A. 21784
			23a. P. rt1. Enter the disease, or s ock, r heart failure. List	complications that caused only one cause on each li	d the death. ine.	Do not ent	er the mode of dying	, such as cardiac	or respiratory ar	rest,		Approximate Interval Between
	Pnysician		Immediate cause (Final dise se or condition	ASPHY	X/Λ	BY	HANGING					Onset and Death
	/Medical Examiner		resulting in death)	Due to (or is	a consequer							
	Lxummer	Ļ	Sequentially list conditions,	b								
	ed sit	Examiner	if any, leading to immediate cause. Enter Underlying	Due to (or as	a consequer	ice of):						
_	and and II-trar	xan	that initiated events resulting in death) Last	c Due to (or as	a consequer	ice of):						
8760,	rate be executed hysician and the burial-transit	aiE				,-						
687	ate the	edicai		d								
XO	The law requires that the death certific tie has been signed by the attending ploage 2 should be detached for use as so	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome						23d F	ate of delive	ny.
ă	death a atte	cial	in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant at			Ectopic pregnancy Other (specify)					Day Year
0	that the d	hys	9 Unknown	9□ Unknown								
ď.	es tha igned I be det	by P	Part II. Other significant condition	ns contributing to death b	out not resultin	ng in the u	nderlying cause give	in Part I.	23e. Did to	bacco use co	ntribute to th	e cause of death?
Records,	quire an sig uld b	ed t							1 🗆 Y	'es 2 □ No	3 🗌 Prob	abiy 4 🗖 Inknown
000	s been 2 shoul	piet							24a. Was		. Were autor	osy findings available
Re	The lay	Completed							autop perfor	med?	death?	npletion of cause of 2X No
Vital		Ф	25. Was case referred to medical					26. Place of Deat		2 No	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	ZANO
>	S D	To B	examiner? 1XYes 2□ No	Hospital: 1 ☐ Inpatie	ent 2□ER	/Outpatier	t 3 DOA Other		ome 5 Resid		ther (Specify	·)
	Ta = E		27. Manner of Death	28a. Date of Inju (Month, Da	ıry 28	b. Time of			28d. Describe h			3
<u>Ö</u>	ittendir death. ctor: Af / the fur	atic	1 ☐ Natural 5 ☐ Pendin investig	pation April 3.20	005 1	500	O M 1□Y		ASPHXX	MA BY	HANG	SING
Division	l or Atter de Directo	Certification:	3 Suicide 6 ☐ Could r 4 ☐ Homicide determ	not be Blace of Inju	jury - At home	, farm, str	eet, factory, office		28f. Location (S	treet and Nun	nber or Rura	Route Number,
Q	ital o	Cer		1401					City or Tow	Erestout	DOW!	136
	Hospital or Attending 24 hours after death. Funeral Director: After tely filled in by the fune	edicai	(Check only 2 Milegical I	g Physician: To the best of Examiner: On the basis of	of my knowle	dge, death	occurred at the time	, date and place,	and due to the d	ause(s) and n	nanner as st	ated.
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Med	one)	and manner sta	ated.							
	Wit To	_	29b. Signature and title of certifier	2 Circ			29c. License		1	29d. Date sign	ea (Month, L	Jay, Year)
7	WSL	10	1 months	MD D	CPUTI	1	17180	06/		April	3 20x	5
	4		30. Name and address of person	who completed cause of d	11'	a) (Type,	Print)	1 . 11	Λ1.	1 )	· ·	- )
	Sta	to	31. Date filed (Month, Day, Year)		ar's Signature	H.11	LI, LV	row. U.	e, Mary	1940	2100	13
	Registra		APR 0		a de a	K.	Sand !		1			

			ricas	State of M						•		•
			1 - For State Registrar	State of Ma	aryland /	-	ficate of l		iu ivien		71100	12025
			Hegistrar     Decedent's Name (First, Middle, and American Street, Middle)	Last)		Oera	TCATE OF E	Jean	2. 0	Reg. No	lo:	3. Time of Death
	Physici		MARGUERIT		FLEM	0110	3		1		ay Yee	-m.
	/Medic Examin		4e. Facility Name (If not institution of the popular of the popula				b. City, Town, or	Location of [			ic. County of De	
	LAGITIT		4101 OLD NATIO	NUKSING	Home	1	MOUNT	AIRY,	MAR	MLAND	CARRI	OLL
	Funeral			. Sex 7. Ag	e (In yrs. last	birthday)	f Under 1 Year Ionths Days	If Under 24	Hrs. 8. C	Date of Birth Month, Day, Yea		irthplece (State or Foreign Country)
6	Director		218-54-1196	1□M 2MF	88	Yrs.	lonting Days	Tiours		ne 14,		yland
	and w		Usuel Residence of Decedent  10a. State 10b. County		10c. City. To	own or Local	ion					10d. Inside City Limits
	Aaryla F sho	ō										1 ☐ Yes 2 ☑ No
	28a-	Director	MD Howard  10e. Street and Number		Mt. A	lry	10f. Zip Code			10g. (	Citizen of What (	
	3a or		702 E. Watersvil	1e Road			21771					•
	ms 2	by Funeral	11. Marital Status	12. Was Decedent		13. Wa	s Decedent of Hi	ispanic Origin	? (Specify			nerican Indian,
9	after or its	Ē	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ I If Yes, Give				n, Mexican, F Specify:	Puerto Hica	n, etc.)	Black, Wh	nite, etc.
8	within 72 hours after death with the Maryland ene. than "natural", or Items 23s or 28s-f show he Madical Examinel must be notified at	d b	3   Widowed 4 □ Divorced	Year or Dates:			163 2/2/140	зресну.			Specify: Wi	nite
5	72 h "natu	Completed	15. Decedent's (Specify only highest)		11	(Give kir	t's Usual Occupa d of work done o	furina most o	f working	16b.	Kind of Busines	s/Industry
12	within lene. then the Mis	m d	Elementary/Secondary (0-12)	College (1-4or f			NOT use retired	)		***	1	
D D	De filed within 72 hours after death with the Marylan ital Hygiene. No other than "natural", or items 23a or 28a-1 show event, the Madical Examiner must be notified at	ပိ	17. Father's Name (First, Middle, La	est)	П	lousew	LIE	18. Mother's	Name (Fir	st, Middle, Maide	er home	
an	Mental Mental arked o	To Be	Harry Americus K	ing				Mamie	Hatfi	e1d		
ary	S D E E	-	19a. Informant's Name/Relationship		1	19b. Mailing				ute Number, City	or Town, State,	, Zip Code)
Ž	alth a alth a 27 is		Harry Fleming, J	r. So	on	722 E.	Waters	ville	Rd.	Mt. Air	7. MD 21	1771
ore	of He of He riterr		20a. Method of Disposition 1   ☐ Burial 2 ☐ Cremation 3		20b. Place	of Dispositi		a)	Date	20c.	Location - City of	
Ĕ	Page: ment o ant: If ury or		'4 □Devation 5 □Other (Spe			ar Spr	ings Ce	n.	pril 2005		lar Spi	cin s, MD
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra		21. Signature of Funeral Service Lic			22. N B111	ame and Addres	s of Facility	meral	Home &	Cremate	ory P A
	0 D = 4 0			umo		12	2 W. 01	d Libe	rty R	oad Wi	nfield,	Pry, P.A. MD 21784
			23a. P. rt1. Enter the disease, or connect, or heart failure. List on						irdiac or res	piratory arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disea to or or ndition resulting in eath)		-		, WE MH	AIMO				TEN DAYS
3	Examiner			Due to (or as	a consequent	ce of):						
	i	e	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a consequent	ce of):						
	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying that initiated events									
oʻ	ite be executed lysician and he burial-transit		resulting in death) Last	Due to (or as	a consequenc	ce of):						
3760,	nte be nysica he bu	cal		d								
68	leath certificate attending phy I for use as the	Physiclan/Med	IF FEMALE:		W====							Market Land
Вох	ath ce ttendi	an/l	23b. Was decedent pregnant in the past 12 mpnths?	23c. ff yes, outcome 1 ☐ Live birth	2 Fetef dea	ath 3 □Ed	topic pregnancy				23d. Date of de Month	elivery Day Year
o.	the a	/sic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□Pregnant at 9□Unknown	t time of death	5 □ 0	ther (specify)				TV-GHUT	Day 1 Sai
P.0.	that the de ed by the detached	Ph	Part II. Other significant conditions	s contributing to death b	out not resulting	a in the unde	riving cause give	n in Part I.		23e. Did tobacco	use contribute	to the cause of death?
ds,	uires tha signed id be de	d by	HYPERTEN				, ,			1 🗌 Yes	2 <b>⊡</b> √No 3 □ F	Probably 4 🗀 Unknown
COL	w requir been si shoufd	lete	SENTLE C	AITMAMA						24a. Was an	24h Were	autopsy findings available
Division of Vital Records,	The lav	Completed	OSTEC AP						-	autopsy performed?	prior to death?	completion of cause of
tal	vician: Th certificate rector, pag	0	25. Was case referred to medical	, , , , ,				26. Place of		eck only one)	O TLIYE	s 202/No
<u> </u>	lysici is car direc	To B	examiner? 1 ☐ Yes 2 ▼ No	Hospitaf. 1 Inpatie	ent 2 ER/	Outpatient	3 DOA Othe	1		5 Residence	6 Other (Sp	ecify)
0	ng Ph Iter th		27. Manner of Death  1 Watural 5 Pending	28a. Date of Inju (Month, Da		b. Time of Injury	28c. Injury Work			Describe how in		
Sio	endir eath. or: A the fu	catle	2 Accident investigat					res 2□No				
Ξ̈	for Att	Certification:	3 Suicide 6 Could not determine	289. Prace of Inf	jury - At home, tc. <i>(Specify)</i>	, farm, street	factory, office			ocation (Street a City or Town, Sta		Rural Route Number,
	pital ours a eral D		29a. Certifier 1 V Certifying	Dhysisian Tathahan	at any banaula	dae deeth -						
	To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the	edical	(Check only 2 Medical Ex	Physician: To the best aminer: On the basis of and manner sta	f examination	and/or inves	ligation, in my or	pinion, death	occurred at	the time, date a	s) and manner and place, and du	ue to the cause(s)
	To the formal fo	Me	29b. Signature and title of certifier	10 - Bri			29c. License	number		29d. D	ate signed (Mor	nth, Day, Year)
	12		1 1 2 - Ou	Manage			D.	3 5 Li.	09	Ag	RIL.	2, 2005
	MI		30. Name and address of person who N. R. VELLAWK	no completed cause of c	death (ftem 23	a) (Type, Pri	10032	to 100	PIL	A:7 #05	Mo	21042.
	10		IV. B. VELLANK	1, 4055,	UNE VIC	nrea	JANIE,	-6 100	, , ,		7 1 12	~ ZT = .
ĮS-	Sta		31. Date filed (Month, Day, Year)	. 21	rar's Signature							
Dn	Registr MH 17 Rev 1/20		APR 0_6	2005	and h	The Age	ark)	<u></u>				
υH	IVID 17 DBV 1/20	NI										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April 8 2005 Physician Mary Ethel Flack 1640 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Medical Center Annapolis Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral**  Birthplace (State or Foreign Country) 1□ M 2□F 218 18 3220 85 1920 Virginia **Director** January 16 Usuel Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location or 28a-f show 10d. Inside City Limits the Medical Examiner must be notified at Maryland Prince Georges Bladensburg Director 1 Tyes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "neturel", or Items 23a 5005 Townsend Way 20710 United States death Was Decedent Ever in U.S Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian e filed within 72 hours after d al Hygiene. other then "neturel", or item Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: white þ 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygient Important: If item 27 Is marked other the eny injury or other traumatic event, Italy Once. cashier retail sales/food 8th 17. Father's Name (First, Middle, Last) Robert Lee Wiseman 18. Mother's Name (First, Middle, Maiden Sumame) ROSie Zella Harris Be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bonnie J. Canter - daughter 1600 Mission St. Owings MD 20736 20b. Place of Disposition (Name of cemetery, crematory or other place) April 13 2005
Metropolitan Funeral Service 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Alexandira Virginia \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home MA 4405 Broomes Is. Rd. Port Republic MD 20676 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** a ischemic colitis days /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician Physician/Medicai the attending IF FEMALE esn. 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy ŏ in the past 12 months? Day Year 4☐Pregnant at time of death 5 Other (specify) the ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 至 nknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed certificate 1 Yes 2**3**No 2 🗌 No 1 Tes To the Hospitel or Attending Physicien: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other. 1 Yes 2 No ↑ Inpatient 2 ER/Outpatient 3 DOA P 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manger of Death 28b. Time of 28d. Describe how injury occurred Certification: After Injury Natural 5 Pending death. M 1 ☐ Yes 2 ☐ No 2 Accident investigation Director; 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a To the Funerel D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) H0053369 4/8/05

State Registrar

Anne Arundel Medical Center Annapolis MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2005 ▶

31. Date filed (Month, Day, Year)

MAO Nancy Snow

32. Registry's Signature

		1 - For State Registrar	State of Ma	ryland / Depa	artment of I rtificate of			giene Reg. No. () () [	10007
Physic	cian	Decedent's Name (First, Middle, Last					2. Date of Dea Month	Day Year	3. Time of Death
/Med	ical	RALPH  4a. Facility Name (If not institution, give	A atmost and sumber!	G]	LL City Town	as Location of Day	APRIL	7 2005	4:45 P M
Exam	iner		TREET			or Location of Dea ER SPRIN		4c. County of Death MONTGOM	
Funera		Social Security Number 6. S		(In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs	8. Date of Birt		DRI place (State or Foreign untry)
Directo		5//-28-344/	M 2□F	83 Yrs.	Months Days	Hours Min			hington,D.C
and		Usuel Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits
Maryl.	ō	Md. Montgo	mery	Silver					1 ☐ Yes 2 ☑ No
r 286	rec	10e. Street and Number			10f. Zip Code			10g. Citizen of What Cou	untry?
th witl	Funeral Director	12418 Flack Stree	t			20906		United St	ates
r dea	Iner	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S. 13.	Was Decedent of I	Hispanic Origin? (S an, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - Amer Black, White	
36 s afte	) F	1 ☐ Never Married 2 ☐ Married 3 Ø Widowed 4 ☐ Divorced	1 ⊠Yes 2 □ N If Yes, Give	0	1 ☐ Yes 2 No	Specify:			White
1215-0036 within 72 hours after death with the Maryland one. than "patural", or items 23e or 28e-f show the Marical Examiner reast tendified at	Completed by	15. Decedent's Edu	Year or Dates:	16a. Dece	dent's Usual Occur	pation		16b. Kind of Business/li	ndustry
215	plet	(Specify only highest grad	e completed) College (1-4or 5-	life.	kind of work done DO NOT use retire	during most of wo d)	rking		
21 ed will rgien er th	Con	12	0		air Supe	rvisor		Telephone	e Company
be fill Hall Hall Hall Hall Hall Hall Hall H	Be	17. Father's Name (First, Middle, Last)					me (First, Middle,	•	
ryla hould d Mer marke	၉	William Gill  19a. Informant's Name/Relationship (Ty	roo Print	10h Mailie	a Address (Ctmat	Eva	Griff:		- 0-41
Ma nd 2 s lith an 27 is r		R. David Gill / S						r, City or Town, State, Zi nsville, Md	
s 1 ar f Hea item		20a. Method of Disposition		20b. Place of Dispo cemetery, crer			Date	20c. Location - City or T	
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural; or items 23e or 28e-f show any injury or other treumatic event, it is Marical Examiner; and be inclifted at	?	1,⊠ Burial 2 □ Cremation 3 □ F `4 □ Donation 5 □ Other (Specify)			.11 Cemet		/12/05	Suitland	, Md.
alti mmit. sparin porte ny inju		21. Signature of Funeral Service Licens	99	22	Name and Addre	ss of Facility	r Funeral		
m goess		23a. Part1. Enter the disease, or compl	auren		P.O. Bo	x 5038,	Laytons	sville. Md.	20882
Cate be executed  Physician and bhysician and physician and physician and street bruial-transit	Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a CORON Due to (or as a ATRIN	consequence of):  ARY ART1  consequence cf).  L FIB RIL  consequence of):	ERY DIS				Onset and Death
the death certifute of the death certifute of the attending ached for use as	Physician/Medical	in the past 12 months?  1 Yes 2 No 9 Unknown	3c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at t	2 ☐ Fetal death 3 ☐ ime of death 5 ☐	Ectopic pregnancy Other (specify)			23d. Date of deliv Month	ery Day Year
COTGS, P w requires that s been signed t should be det	þ	Part II. Other significant conditions con DIABETES A		t not resulting in the u	nderlying cause giv	en in Part I.	23e. Did to	bacco use contribute to t es 2√No 3□ Prof	he cause of death? bably 4 DUnknown
UNISION OT VITAL HECOTOS, to a Attending Physicien: The law requires to after death.  Director: After this certificate has been signed in by the funeral director, page 2 should be a	Completed						24a. Was a autops perform	y prior to co	opsy findings available impletion of cause of
VITAL I sicien: Th certificate irector, pag	9 Be	25. Was case referred to medical examiner?  1 Yes 2 No	lospital:	t 2 ER/Outpatien	· all post Oth		ath (Check only on	e) ence 6 □Other (Specia	
g Phys g Phys er this eral di	n: To	27. Manner of Death	28a. Date of Injury	28b. Time of	The state of the s			ow injury occurred	79)
Vitending I death. ctor: After y the funer	atlo	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	Yeer) Injury		Yes 2 □ No			
3 to # 15 s	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injurbuilding, etc.	ry - At home, farm, stre (Specify)	eet, factory, office		28f. Location (Si City or Town	reet and Number or Rura n, State)	al Route Number,
the Hospitei hin 24 hours a the Funerei Inpletely filled	edical	29a. Certifier (Check only one)  Certifying Physical Examination (Check only one)	sician: To the best of ner: On the basis of and manner stat	examination and/or inv	occurred at the tir restigation, in my c	ne, date and place pinion, death occu	, and due to the carred at the time, d	ause(s) and manner as s ate and place, and due to	tated. c the cause(s)
to the Huithin 24 To the Fo	M	29b. Signature and title of certifier	/		29c. Licens		2	9d. Date signed (Month,	Day, Year)
HILL	1	29b. Signature and title of certifier			D001	1959		04/08/05	
, –		30. Name and address of person who co	DR. S	ILVERSPRI	NG, M	D 20	902	AMAN SI	BAL, M.D.
St Regist	ate	31. Date filed (Month, Day, Year) APR 11 20	05 32 Aegistra	's Signature	ele				

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Dav April 7, 2005 Grasso 12:35a <sup>M</sup> /Medical Antonina 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Silver Spring Holy Cross Hospital If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (Sountry)
October 4, 1913 Sicily **Funeral** 9. Birthplace (State or Foreign Months Days Hours Min. 1 □ M 2 ₩ F Director **722 12 14** Usuel Residence of 91 12 1407 Decedent 10b. County 10c. City, Town or Location 10a. State 28a-f show 10d. Inside City Limits Examiner rust by notified at Director Prince George's College Park 1 Yes XX No Maryland 10f. Zip Code 10g. Citizen of What Country? or Itema 23a 20740 USA Funeral 9014 Rhode Island Avenue #308 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. e filed within 72 hours atter all Hygiene.
I Hygiene. Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give ★ Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White þ 3

Widowed 4 □ Divorced Completed other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home Home Maker 12 permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked other any finiury or other traumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Antonina Polilo Salvatore Valenza 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2836 Sudberry Lane Bowie, Maryland 20715 Lawrence W. Grasso / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State ^ 4 □ Donation 5 □ Other (Specify). Ft Lincoln Cemetery 4/11/2005 Brentwood, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines Rinaldi Funeral Home 11800 New Hampshire Ave Silver Spring, MD 20904 Rant 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Filysician Myocardial Infarction disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner The law requires that the death certificate be executed the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. 1 9 Unknown 9 🗆 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Division of Vital Records, s been signe should be 1 ☐ Yes 2 🕏 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed? 2 No 1 Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To Hospital: 1 ☐ Yes 3KXNo 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending within 24 hours after death To the Funeral Director: A investigation 1 ☐ Yes 2 ☐ No 2 Accident the 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) illed in by 4 - Homicide 1 Scrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) the 29b. Signature and title of certifier 0 29c. License number 29d. Date signed (Month, Day, Year) Muc mo April 7, 2005 D0061390 B 30. Name and address of person o completed cause of death (Item 23a) (Type, Print) 1500 Forest Glen Road Silver Spring, Maryland Charles Oh, M.D. 31. Date filed (Month, Day, Year)
APR 11 State Registrar

			1 - For State Registrar	State of Maryland / D	Departmer	nt of Health a	and Mental Hyg	_	1000
			Registrar  1. Decedent's Name (First, Middle, Las		Centrical	te of Death	2. Date of Dea	Reg. No. 4- UU	3939
	Physici	an		Gates, Jr.			Month	Day Year	3. Time of Death
	/Medic		4a. Facility Name (If not institution, give	· · · · · · · · · · · · · · · · · · ·	4h City	Town, or Location of	April 9	4c. County of Deat	9:58 A M
	Examin	er	7010 Silver Run R		1	a Plata	Death:	Charle	
	Funeral		5. Social Security Number 6. S	ex 7. Age (In yrs. last bin	thday) If Unde	r 1 Year   If Under	24 Hrs. 8. Date of Birti	h Q Rie	
	Director		216-16-0088	XDM 2□F   81	Yrs. Months	Days Hours	Min. (Month, Day Dec. 18	1923 Wash	hplace (State or Foreign untry) ington DC
	pu 🖈		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town					
	shor shor	'n				ъ .			10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	28a-f	ecto	Maryland Charles 10e. Street and Number	7010 5	ilver R	UN KOAU		10= Chinas of Mh - 10-	•
	within 72 hours after death with the Maryland one. Than "raturel", or ltems 23a or 28a-f show ha Medical Examiner must be notified at	by Funeral Director	7010 Silver Run R	nad	101. 21	20646		10g. Citizen of What Co USA	untry r
	Jeath TIS 23	era	11. Marital Status	12. Was Decedent Ever in U.S.	13. Was Dece		gin? (Specify Yes or No-		rican Indian.
ထ	or Ite	Ē	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🕅 No			gin? (Specify Yes or No- n, Puerto Rican, etc.)		e, etc.
8	rel', c	d by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1 ☐ Yes	2 No Specify:		Specify: W	hite
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au	id be ental ked o	To Be	Earl Pembroke Gat				onsuelo V. I	,	
Maryland 21215-0036	shound M	-	19a. Informant's Name/Relationship (7		. Mailing Address		or or Rural Route Numbe		Tip Code)
	alth a alth a 27 ls		Anna Gates - Wife	70	10 Silv	er Run Ro	ad, La Plata	a, MD 20646	
S. C.	of He of Herr		20a. Method of Disposition  1/□ Burial 2 □ Cremation 3 □	20b. Place of cemeter	Disposition (Na.	me of other place)	Date	20c. Location - City or	Town, State
altimore,	Pages ment of l ant: If its ury or o		'4 □ Donation 5 □ Other (Specify	The Indiana in the In	ul's Cer	metery	4-14-05	Waldorf, MD	
Balt	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene.  The partment of Health and Mental Hygiene.  The Medical Examiner must be notified at once.		21. Signature of Funeral Service Licen	see M01391	22. Name ar	nd Address of Facilit	y Ome		
	20 E 3 G		JAN TYGOL	-			óme Waldorf, MD		
	Pnysician		23a. Part1. Enter the disease, or comp shock, or heart failure. List only Immediate Cause (Final disease or condition	one cause on each line.	not enter the mod	le of dying, such as	cardiac or respiratory arr	rest,	Approximate Interval Between Onset and Death
f	/Medical		resulting in death)	a. Due to (or as a consequence	h: 1 -1	/	1		
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<u>≥</u>	or Attendate death Director: in by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, far building, etc. (Specify)	m, street, factor	, office	28f. Location (St City or Town	treet and Number or Rui	ral Route Number,
	ital or A rrs after ral Dire						<b>V</b>		
	To the Hospital c within 24 hours af To the Funeral D completely filled in	Medical	29a. Certifier 1 ✓ Certifying Ph: (Check only one) 2 ☐ Medical Exam	ysician: To the best of my knowledge, niner: On the basis of examination and	, death occurred Vor investigation	at the time, date and , in my opinion, deat	d place, and due to the ca h occurred at the time, d	ause(s) and manner as ate and place, and due	stated. to the cause(s)
	To the within 2 To the complet	Mec	29b. Signature and title of certifier	and manner stated.		c. License number		9d. Date signed (Month	
)	- \$ - ō		> moral	w	T	10021		4/12/05	
			30. Name and address of person who d	completed cause of death (Item 23a) (		JUU (S.1)		111-107	
j٧	P 10		Dr. Michael A. Le	atherwood, 12070		e Center,	#202, Wald	orf, MD 206	02
	Sta		31. Date filed (Month, APR 2 2	2005 32. Registrar's Signature	Show	K. a			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** APRIL 10°. 2005 CALVIN BOYD GALBREATH 8:30 A M /Medical 4a. Facility Name (If not institution, give street and number) 4h City Town or Location of Death 4c. County of Death **Examiner** FORT WASHINGTON HOSPITAL FORT WASHINGTON PRINCE GEORGES If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth 9. Birthplace (St. Month, Day, Year)
JUNE 15, 1952 KENTUCKY 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1**X**XM 2□ F Days Hours Months 407-70-0883 52 Yrs Director Usual Residence of Decedent 10c. City, Town or Location 10a State 10h Counts 10d. Inside City Limits 28a-f ehov Itam 27 Ia markod othar than "natural", or items 23a or 28a-1 ehov other traumatic event, the Modical Examinar must be notified at 1 Yes 2 No Director MARYLAND CHARLES WALDORF 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 7970 PEBBLE CREEK COURT 20603 UNITED STATES Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1∑Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced BLACK 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry and Mental Hygiene. 2 YEARS Elementary/Secondary (0-12) ADMINISTRATOR FEDERAL GOVERNMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be CARL GALBREATH BOBBIE ANN THOMAS LEWIS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 si ment of Health and ant: If Itam 27 land JUANITA GALBREATH / WIFE 7970 PEBBLE CREEK COURT, WALDORF, MARYLAND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State TRINITY MEMORIAL GARDENS APRIL 16, 2005 WALDORF, MARYLAND any injury o \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Senature of Furieral Service Licenses 120IA C. THURNION JOHNSON MO0583 Name and Address of Facility
RYTUN FINERAL HOME PA
PALLVINGSION ROAD, INDIAN HEAD, MARYLAND 20640
App 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death disease Immediate Cause (Final disease or condition resulting in death) Atheroscleratic coronary Physician ONKNOWN /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) use as the burial-tranattending physician and Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) the detached Š 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has page 2 s 2 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) exammer' Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Man r of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural Injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 - Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, Physician: or Attanding Diractor: filled in by 24 hours a Medical completely within 2

the Maryland

filed within 72 hours after

Baltimore, Maryland 21215-0036

State Registrar 29a. Certifier

(Check only one)

29b. Signature and title of centile

Sachdera M.D. Deepak 2 2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Resistrar's Signature

MO

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

10, 2005

April

			State of Mar				•		egible.	
		•	For State Of Walt State Registrar		ertificate of			Reg. No.	005	1391.1
	Physici	an	Decedent's Name (First, Middle, Last)				2. Date of Dea	ath Day	Year	3. Time of Death
	/Medic	al	Robert Merrill Gochneau	r, Sr.	T # 65 T		April	7,	2005	16:55 M
	Examin	er	4a. Facility Name (If not institution, give street and number)  569 Deans Bank Road		North I	or Location of Death		Cec	ounty of Death	
	Funeral			in yrs. last birthda	) If Under 1 Year	If Under 24 Hrs.	8. Date of Birt (Month, Day			ace (State or Foreign
	Director		273 20 1948 <sup>1⊠M 2□F</sup>	80 Yrs.	Months Days	Hours Min.	July 26		Ohio	(ry)
pue	<b>&gt;</b>		Usual Residence of Decedent  10a. State 10b. County 1	0c. City, Town or I	ocation		3			0d. Inside City Limits
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basin with the Maryland	popartment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itams 23a or 28a-f show any injury or other traumatic event, the Medical Exercit efficients be notified at once.	Director	Maryland Cecil N  10e. Street and Number	lorth Eas	10f. Zip Code			10g. Citizer	n of What Count	try?
5 9	23a o 151 ke		37 Zion Acres Road		21901			Unite	d State	c
9	ams	Funeral	11. Marital Status 12. Was Decedent Ev- Armed Forces?	er in U.S. 13	. Was Decedent of H	Hispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No-	14.	Race - America Black, White, e	an Indian,
o g	orl	by Fu	1 Never Married 2 Married 1 Yes 2 No If Yes, Give 3 Widowed 4 Divorced Year or Dates:	1942-	1 ☐ Yes 2 🔀 No				ecify: whi	
2.13-0030	atural Per Es	ed b	15. Decedent's Education	1962 16a. Dec	edent's Usual Occur	ation			of Business/Ind	
מ א מיק	Medical Medical	plet	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	(Giv	edent's Usual Occup re kind of work done DO NOT use retire	during most of work d)	ing			
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yland yldbe	od oth	Be	17. Father's Name (First, Middle, Last)			18. Mother's Nam	e (First, Middle,	Maiden Su	mame)	
	d Mer marke matic	은	Asa Gochneaur  19a. Informant's Name/Relationship (Type, Print)	10b Mai	ling Address (Street	Hazel Ev		r City or T	oum State 7in	Codel
Ma	Ith an 27 is 1		Kelly Howell, Daughter	0.00				1000		ar-in-
<b>a</b>	f Hea item otha	1	20a Method of Disposition	20b. Place of Disi	Deans Ban		Date	20c. Local	tion - City or Tox	wn, State
	nent chart chart chart chart chart if it is or arry or		A □ Buriah 2 □ Cremation 3 □ Removal from State  '4 □ Donation 5 □ Other (Specify)		ematory or other pla st Method eterv		1 12,	North	east,Ma	erul and
	apartn sports ny inju		21. Signature of Punyal Service Licensee		22. Name and Addre	ess of Facility Cr	ouch Fu	neral	Home	
D a	10 E M 0		Jan Her						100	land 21901
			231. art1. Enter the diseas. It is might be that caused the shock, or heart failure. List only one cause in each line.			_	or respiratory ar	rest,		Approximate Interval Between Onset and Death
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ָה יַּ ס פֿ	by th	hys	9 Unknown							
The law requires that the death	signec be d	by	Part II. Other significant conditions contributing to death but	<b>—</b> — 11.	underlying cause giv	ven in Part I.	23e. Did to	/		a cause of death?
Mecords,	peen	Completed	Paratte allowarden	COL DIVI			-			
He He	page 2	dwo	1 washing and ordered	<u> </u>			24a. Was autop	sy rmed?	prior to com death?	sy findings available injection of cause of
		0	25. Was case referred to medical			26. Place of Deal		20 No	1 🗆 Yes	2 No
a	iis certific director,	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient	2 ER/Outpati	ent 3 DOA Ott	200	ome 5 Resid		Other (Specify,	Mindense
וס נו	h. After this funeral di		27. Manner of Death 12 Natural 5 ☐ Pending (Month, Day Y	'ear) 28b. Time Injury		ry at	28d. Describe h	now injury o	ccurred	
SION	death. ctor: A y the fu	cat	2 Accident Investigation	As because for our		Yes 2 □ No	206 Landing (6	Name & a mark & a	( b 0 )	0-1-1-1
	after of Direction by	ertiflcation;	4 Homicide determined 28e. Place of Injury building, etc.	(Specify)	street, factory, office		28f. Location (S City or Tow	n, State)	rumber or Hurai	Houte Number,
4	within 24 hours after death To the Funeral Director: completely filled in by the	O	29a. Certifier Certifying Physician: To the best of	my knowledge, dea	ath occurred at the ti	me, date and place,	and due to the	cause(s) an	d manner as sta	ited.
A OH	n 24 t he Fu pletely	edical	(Check only one) Medical Examiner: On the basis of examiner state	kamination and/or	investigation, in my o	opinion, death occur	red at the time, o	date and pla	ace, and due to	the cause(s)
5	within To the	Σ	29b. Signature and title of certifier	/	29c. Licens	se number		29d. Date s	igned (Month, E	2005
			> files Jan Ufal	/	y s	37.764		A.	281	700)
5	+IVA		30. Name and address of person who completed cause of dea	th (Item 23a) (Type	Print) DO CO 1	M42	gland			
<i>3</i>	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's	Signature	•	(	0			
	Registr		APR 1-2 2005 Securit St	Aprile						

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No." 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 2005 Year 1550 April 10, **Physician** Wanda Katherine Gross /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** ALLEGANY CUMBERLAND Memorial Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number Months Days Hours **Funeral** 1 □ M 2 🔀 F Jan. 17,1925 Maryland 80 164-20-3194 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location the Maryland 10b. County 7 is marked other than "netural", or Items 23e or 28e-f show treumatic event, Ite Modical Examiner must be notified at 1 Yes 2 □ No Paw Paw Morgan WV Direct 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 25434 **USA** 107 Winchester St., P.O. Box 147 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: Baltimore, Maryland 21215-0036 3 Widowed 4 □ Divorced White à 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Completed d 2 should be filed within 7 in and Mental Hygiene. 7 is marked other than "r College (1-4or 5+) Elementary/Secondary (0-12) Registered Nurse 4 Nursina 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Jessie Warnick Bruce Yommer 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 is rr any injury or othar treum 900.9. P.O. Box 50, Paw Paw, West Virginia 25434
ace of Disposition (Name of Date 2c. Location - City or Town, State John D. Gross/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Grantsville Cemetery April 16,2005 Grantsville, MD 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Facility Newman Funeral Homes, P 179 Miller St. P.O. Box 275, Grantsville, Maryland 21536 Newman Funeral Homes, P.A. 21. Signature of Funeral Service P Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) MASSIVE BRAIN HEMORRHAGE MINUTES Physician /Medical Due to (or as a consequence of): YEARS UNTREATED HYPERTENSION Examiner Sequentially list conditions, Due to for as a consequence offi n any, leading to immedicause. Enter Underlying Cause (Disease or injury physician and s the burial-transit The law requires that the death certificate be executed Exam that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical attending IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Year Month Day in the past 12 months? 5 Cher (specify) 4 Pregnant at time of death signed by the a 1 Tyes 2 No 9 Unknown Ö 9 Unknown ۵ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records. 3 Probably 4 Munknown 1 ☐ Yes 2 ☐ No Completed should been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed page 2 s 2 No 1 ☐ Yes 2 No 1 Yes this certificate Hospital or Attending Physician: 26. Place of Death Check onl one 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 SER/Outpatient 3 DOA 1 Inpatient Certification: To 1 Tyes 2 V No 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death After 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No after death. investigation 2 Accident the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide filled in by 4 THomicide within 24 hours a To the Funeral C Example 1881 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) completely 29d. Date signed (Month. Day, Year) 29c. License number 29b. Signature and title of certifier 12, 2005 April D0054411 e and address of person who completed cause of death (Item 23a) (Type Perly Calkins M.D. 500 Memorial Cumberland, Maryland 21502 Avenue Bewerly Calkins M.D. 31. Date filed (Month, Day 32. Registrar's Signature State 2005 Registrar

## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	State of N	Certificate		Reg. No. 2 0 0 5 1 2 0 1 2
Dhysisia	Decedent's Name (First, Middle, Last)		2. Date of I Month	Day Year
Physicia Medica	Minnie Lois GROVE		April	9 2005 5:25 A.M.
Examine	4. Tarille, blame (If not incitivation give etreet and number	")	4b. City, Town, or Location of De	
	Julia Manor Health Care	ne (In vrs. last hirthday) If Under 1 Ye	Hagerstown  ar   If Under 24 Hrs.   8. Date of I	Washington
Funeral	5. Social Security Number 6. Sex 7. A	ge (In yrs. last birthday) If Under 1 Yes. Months Da	ys Hours Min. (Month,	Day, Year) Country)
Director	234-60-3263 Usual Residence of Decedent	67	Oct.	13 1937 Kentucky
pue 🔭	10a. State 10b. County	10c. City, Town or Location		10d. Inside City Limits
Mary 4 sh	N 1 H hámhan	Hanamatarn		1 ☐ Yes 2八 No
28 the	Maryland Washington 10e. Street and Number	Hagerstown 10f. Zip Cod		10g. Citizen of What Country?
3a o			21740	U.S.A.
death	11 Marital Status 12. Was Deceden	t Ever in U,S. 13. Was Decedent	of Hispanic Origin? (Specify Yes or cuban, Mexican, Puerto Rican, etc.)	No- 14. Race - American Indian, Black, White, etc.
patitificity, Matylatin Z.1.2.19-0020 permit. Pages 1 end 2 should be filed within 72 hours efter death with the Marylend Depertment of Heelth end Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Madical Examiner must be notified at page.				Specify:
ours e	3 ☐ Widowed 4 ☐ Divorced Year or Dates	:	to openiy.	White
72 hc	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4o 8 0  17. Father's Name (First, Middle, Last)	16a. Decedent's Usual Oc (Give kind of work do	ne during most of working	16b. Kind of Business/Industry
The Gran	Elementary/Secondary (0-12) College (1-40	r 5+) life. DO NOT use re	tired)	
ygier 7.	8 0	Homemaker	18. Mother's Name (First, Midd	Her own home
d tal tal	17. Father's Name (First, Middle, Last)			ole, Maldell Sullame)
y to ould live arks	Alvin Pickett, Sr.		Vera Gass	mhar Citary Tayer State Tin Code)
2 sh end la m	19a. Informant's Name/Relationship (Type, Print)			mber, City or Town, State, Zip Code)
m 27	Bonnie Grove - Daughter	634 / Jacobs 20b. Place of Disposition (Name o	Court, Eldersbu	20c. Location - City or Town, State
or of the	20a. Method of Disposition  1X Burial 2 □ Cremation 3 □ Removal from State	e cemetery, crematory or other	place)	
Defitition of the plant of the control of the contr	4 ☐ Donation 5 ☐ Other (Specify)			/05 Glasrow, Kentucky
Danit Dependent Dependent Import any in	21. Signature of Funeral Service Lines (see	22. Name and Ad	FITHITC	h Funeral Home
20589	Prolein Santo			erstown, Md. 21740
	23a. Part1. Enter the disease, or complications that caus shock, or heart failure. List only one cause on each	ed the death. Do not enter the mode of line.	dying, such as cardiac or respirator	y arrest, Approximate Interval Between Onset and Death
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/Medical Examiner	Immediate Cause (Final disease or condition resulting in death)	1shirate 1	le um on or	(W
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death cert			20h C	oid tobacco use contributa to the cause of death?
s that the death cert igned by the ettendin be deteched for use i	Part II. Other significant conditions contributing to death	but not resulting in the underlying cause	g	☐ Yes 2☐ No 3☐ Probably 4☐ Unknown
£ & D				2010 00110000
VICAL THE LAW requires that the cartificate has been signed by the rector, page 2 should be deteched				Vas an autopsy enformed? 24b. Were autopsy findings available prior to
w require been si should I			p	erformed? available prior to completion of cause of death?
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VICAI TRE IS Iclan: The Is certificete he rector, page			26. Place of Death (Check on	
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DIVISION  i or Attending efter death.  Director: After d in by the fune	27. Manner of Death 1 Shatural 2	etc. (Specify)	City or	Town, State)
To the Hospital or Attending Phys within 24 hours efter death.  To the Funeral Director: After this completely filled in by the funeral d	29a. Certifier 15 Certifying Physician: To the be	st of my knowledge, death occurred at the	ne time, date end place, and due to	the cause(s) and manner as stated.
n 24 l	one) and manner	stated.		me, date and place, and due to the cause(s)
To the within To the comple	29b. Signature and title of certifier	29c. Li	cense number	29d. Date signed (Month, Day, Year)
		0	52323	4/12/5
	30. Name and address of person who completed cause of	f death (Item 23a) (Type, Print)		1 2 210
5H-1	Dr. Khalid Waseem 11	26 Opal Court	Hagerstomm, 1	Maryland 21 196
Sta	31. Date filed (Month, Day, Year) 2005 32. legi	strar's Signature	•	Maryland 2,740
Registra		A STATE OF THE STA		

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ı	Physici /Medic		1. Decedent's Name (First, Middle, La Sally	Ann		2. Date of Deal		Year	Time of Death		
	Examin		4a. Facility Name (If not institution, given Genesis Eldercan		)	4b. City, Town	n, or Location of Dea LaPlata	ith	4c. County of	of Death	
	Funeral Director		5. Social Security Number 371-26-2591 6. S	Gex 7. Ag	ge (In yrs. last birthda 79 Yrs.	y) If Under 1 Ye Months Day		s. 8. Date of Birth (Month, Day OCt 28	3, 1925	(Country)	(State or Foreign
	show dat	10	Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or					10d. In	nside City Limits
	ith the M or 28e-f	Directo	Maryland Prince (		Ft. V	ashingto	9	1	0g. Citizen of W	hat Country?	☐ Yes ŽŽŽNo
	be filed within 72 hours after death with the Maryland ital Hygiene. d other than "natural", or items 23s or 28e-f show event, If a Medical Examine must be notified at	Funeral Director	12204 Hazel Hill	12. Was Decedent Armed Forces	?	3. Was Decedent of If Yes, specify C	20744 of Hispanic Origin? (suban, Mexican, Pue	Specify Yes or No- rto Rican, etc.)		- American Inc., White, etc.	dian,
-0036	hours aft tural', or l	þ	1 Never Married 2 Narried 3 Widowed 4 Divorced  15. Decedent's E	1 ☐ Yes ZX If Yes, Give Year or Dates:		1 ☐ Yes 2 ☑ !			Specify:	Blac	
Maryland 21215-0036	within 72 lene. than "na	Completed	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4or	(Gi 5+)	edent's Usual Oc re kind of work do: DO NOT use rel Chiatric	ne during most of wo ired)	orking	16b. Kind of Bus	edical	
land 2	buid be filed Mental Hyg arked other atic event, I	To Be C	17. Father's Name (First, Middle, Last Roosevelt Sny				18. Mother's Na	ume (First, Middle, M			
Mary	12 should h and Mer 7 is marke traumatic		19a. Informant's Name/Relationship (				eet and Number or R		-		3)
Baltimore, I	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, If a Medical Examinating must be notified at once.		Kimberly Walton /  20a. Method of Disposition  *X*Burial 2 Cremation 3 C  4 Donation 5 Other (Special	Removal from State	20b. Place of Dis			Date	ash., Ma 20c.Location - C Clinton	City or Town, St	
Baltir	permit. Page Department of Important: If any injury or once.		21. Signatur of Funeral/Service Lice	1/16/05 . Kalas F oad Oxon	uneral	Home P.	. A .				
3	Physician		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition	plications that cause one use on each li	d the death. Do not eine.	nter the mode of o	tying, such as cardia	c or respiratory arre	est,	Appro	roximate val Between et and Death
	/Medical Examiner		resulting in death)	Due to (or as	a consequence of):	PRITY	narw	Conc	nn		
	cuted nd ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	a consequence of):						
8760,	icate be executed physician and s the burial-transit	dical Ex	resulting in death) Last	Due to (or as	a consequence of):						
.O. Box 6	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal death 3	☐Ectopic pregnal			23d. Date Mont	of delivery h Day	Year
۵.	quires that in signed by	þ	Part II. Other significant conditions of	contributing to death b	out not resulting in the	underlying cause	given in Part I.		pacco use contrib		
l Records,		Completed						24a. Was ar autops perform 1 Yes 2	y pri ned? de	ere autopsy fine or to completion ath?	
Viital	ysician: Th is certificate director, pag	o Be (	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital: 1 ☐ Inpatie	2 5 5 D / O / O / O / O / O / O / O / O / O /		)thos	ath Check onl one	9)		
ion of	ding Ph	=	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Da	ry 28b. Time	of 28c. In	4 A Nursing I	Home 5 ☐ Reside 28d. Describe ho			
Division		Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of in	ury - At home, farm, s c. (Specify)	street, factory, office	ee	28f. Location (Str City or Town	reet and Number , State)	or Rural Route	e Number,
	To the Hospital or Within 24 hours after To the Funeral Dir. completely filled in I	edical	29a. Certifier (Check only one) 1 € Certifying Ph	ysician: To the best niner: On the basis o and manner st	of my knowledge, dea f examination and/or ated.	ath occurred at the nvestigation, in m	time, date and place y opinion, death occi	e, and due to the ca urred at the time, da	tuse(s) and manr ate and place, an	ner as stated. d due to the ca	ause(s)
	To the To the complet	Σ	29b. Signature and title of certifier	2)0	1/n	29c. Lice	7062	9	ed. Date sitned (	Month, Day, Yo	'ear)
	90		Tiesury	2 Hw	eath (Item 23a) (Type	a, Print)	no. W	ALD 1	nn	my	2060
	Sta Registr		APR 1 2 2005	32. Registr	ar's Signature						

			State of Maryland / De	partment of Health and I ertificate of Death	•	2005 12015
120	190		Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death
	Physici		ELAINE HENSON			Day Zus 5:31 PM
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	1	4c. County of Death
			WASHINGON ASULMOST HUSPIM	MIXOMA PAR		MONTGOMERY
	Funeral		5. Social Security Number 6. Sex 7. Age (In vrs. last birthd)	y) If Under 1 Year If Under 24 Hrs.	1	9. Birthplace (State or Foreign
	Director		579-38-3379 1 M 2 F 78 Yrs	Months Days Hours Min.	8. Date of Birth Month Day, Yea 4-25-26	TRENTON, NJ
	p ,		Usual Residence of Decedent			
	anyta ehov	<u></u>	10a. State 10b. County 10c. City, Town or			10d. Inside City Limits
	or death with the Marylan tems 23a or 28a-f ehow erniust be notified at	Director	NJ BURLINGTON WILLIN			
	vith th	Dire	10e. Street and Number	10f. Zip Code	10g. (	Citizen of What Country?
	s 23s	ra	80 EVERGREEN DRIVE	08046-2455	U	. S. A.
	after des	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?	<ol> <li>Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert</li> </ol>	pecify Yes or No- o Rican, etc.)	14. Race - American Indian, Black, White, etc.
5	hours after death with the Maryland tural, or Items 23a or 28a-f ehow ul Esaria mirrinal be notified at	by F	1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates:	1 ☐ Yes Ž☐ No Specify:		Specify: BLACK
215-0036	be filed within 72 hours a stat Hygiene. Ind other than "natural, o event, the Medical Exal			cedent's Usual Occupation	16b	Kind of Business/Industry
<u>.</u>	within 72 ene. than "nai	Completed	(Specify only highest grade completed) (G	ve kind of work done during most of wor . DO NOT use retired)	rking	Total of Business/Industry
7	s with	E	Elementary/Secondary (0-12)  4 YEARS	NURSE		PRIVATE
<u> </u>	Hygid other	a	17. Father's Name (First, Middle, Last)	18. Mother's Nan	ne (First, Middle, Maid	en Sumame)
yland	fental fental rked c	To B	DAVID N. RICHARDSON	CARDEL	LA A. RIDG	ET.Y
	2 shoutd and Men la marke sumatic	Г	19a. Informant's Name/Relationship (Type, Print) 19b. Mi	illing Address (Street and Number or Ru		
<u>Z</u>	r 2 mg		ANN L. RICHARDSON-NIECE 80	EVERGREEN DR. WILL	INGBORO, N	J 08046-2455
e e	of Heal			position (Name of rematory or other place)	Date 20c.	Location - City or Town, State
gaitimore,	. Pages tment of tant: If it jury or o		Indibutial 2   Cremation 3   Hemoval from State		0-05 C	ULPEPPER, VA
<u>=</u>	in part		21. Signature of Euneral Service Licensee			NGLER FUNERAL HOME
מ	pen imp any		Theodore Cating Kney	524 - 8TH ST., N.	E. WASH.	, DC 20002
			23a. Part1. Enter the disease, or complications that caused the death. During shock, or heart failure. List only one cause on each line.			Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition WocAzni M IN	The Court		Onset and Death
	/Medical		resulting in death)  a. Due to (or as a consequence of):	V 1/2 ( U 1 U 1 U 1 U 1 U 1 U 1 U 1 U 1 U 1 U		
	Examiner		Sequentially list conditions b.			
_	₽ #	ner	Sequentially list conditions, if any, teating to immediate cause. Enter Undertying Cause (Disease or injury			
	ecute ind trans	Examiner	that initiated events			
/60,	ate be executed hysicien and the burial-transit		resulting in death) Last Due to (or as a consequence of):			
284	physic physic the b	dical	d			
	ling p	Me	IF FEMALE:	10-07-		
X P Q	death certificate e attending phys d for use as the	Physiclan/Med		B □ Ectopic pregnancy		23d. Date of delivery  Month Day Year
	the de y the a	ysic	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 9 ☐ Unknown 9 ☐ Unknown	5 Other (specify)		Day You
7.	res that the de signed by the a be detached f		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I	23e Did tobacc	o use contribute to the cause of death?
g,	requires een signi hould be	d by	,	and any ing decode grown in react.		2 □ No 3 □ Probably 4 □ Unknown
S	~ 9 0	Completed			-	
ě	has has	m d			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
<u></u>	ician: Th certificate rector, pag				1 ☐ Yes 2 🖼	
VItal		o Be	25. Was case referred to fieldical examiner?	Other	ath (Check only one)	
Ö	Phys r this ral di	$\vdash$	1 ☐ Yes 2 ☐ No ☐ Inpatient 2 ☐ ER/Outpa  27. Mann ☐ Death 28a. Date of Injury 28b. Tim.	tent 3 DOA 4 Nursing H	ome 5 Residence 28d. Describe how in	
0	Attending Ph ir death. ector: After th by the funeral	tlon:	1			,a., 000ano
DIVISION	Attendii er death. rector: A by the fu	fica	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm,		28f. Location (Street	and Number or Rural Route Number.
5	P if e	Certificat	4 Homicide building, etc. (Specify)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	City or Town, Sta	ate)
	Hospital 24 hours a Funeral I		29a. Certifier 1 Certifying Physician: To the best of my knowledge, do	ath occurred at the time, date and place	, and due to the cause	(s) and manner as stated.
	the Hos hin 24 hir the Fun hpletely	edical	(Check only 2 Medical Examiner: On the basis of examination and/o	investigation, in my opinion, death occu	rred at the time, date a	and place, and due to the cause(s)
	To the Ho within 24 To the Fu completel	Me	29b. Signature and fittle of certifier	29c. License number	29d. [	Date signed (Month, Day, Year)
		1 1	and on the	35427	2	1-06-7005
0	(5)		10. Name and odress of person who completed cause of death (item 23a) (Type	e, Print)	1	coma PAR MI
			Franks Oxorm mo	1600 Candl "	TVC MAR	Coma PAR MI)
	Sta		31. Date filled (Month, Day, Year)  ADD 1 0 2005			
	Registi	rar	APR 1 2 2005	eta!		
DHI	MH 17 Pov 1/2	001				

			For State Registrar			f Marylan	nd / Depa		of He	ealth a		-		00	5	391	46
	Physici	an	1. Decedent's Nam	e (First, Middle,	Last)	<u> </u>						2. Date of D Month	eath Da	у	Year 05	3. Time of 5:27	
	/Medio	cal	4a. Facility Name (	If not institution,	give street and nur	mber)		4b. City, Tov	wn, or I	Location of	of Death	4		. County		3.21	1 M
	LAGIIII	ici	311 M	nytai	/			Che	125	ert	MY	)		Ke	ent		
	Funeral Director		5. Social Security N 569-46-6		5.Sex 1∭XM 2□F	7. Age (In yrs. 66	last birthday) Yrs.	If Under 1 Y Months D	ays	If Under Hours	24 Hrs. Min.	8. Date of B	irth 20 <sup>Year)</sup>	1938	9. Birthp	lace (State o	or Foreign
	ō		Usual Residence o														
	f show	ō	10a. State MD	10b. County KEn	t		y, Town or Lo Cheste:								11	0d. Inside Ci	ity Limits 2 □ No
	r 28a-i	rect	10e. Street and Nu	<u> </u>				10f. Zip Co	de				10g. Cit	izen of W	hat Coun		
	23a o	ralD	311 Mayf	air Dri	ve			2	162	20			USA				
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If itam 27 is marked other than "natural", or Itama 23e or 28e-f show important: If itam 27 is marked other than "natural", or Itama 23e or 28e-f show any injury or other traumatic event, if a Medical Examinar must be notified at once.	by Funeral Director	11. Marital Status 1 ☐ Never Marr 3 ☐ Widowed	ried 2∰ Marrie 4 □Divorced	Amed Fo	2 □ No ⁄e	t t	Was Decedent If Yes, specify 1 ☐ Yes 2 🔀		spanic Origin, Mexican Specify:	gin? (Sp , Puerto	ecify Yes or N Rican, etc.)	10-	Black	- Americ c, White, Whit	etc.	
5-0	72 ho	eted	(Spec	15. Decedent's	Education grade completed)		(Give	dent's Usual O	ione du	urina most	of work	ing	16b. K	ind of Bu	siness/Inc	lustry	
Maryland 21215-0036	within iene. than the Mo	Completed by	Elementary/Seco	ondary (0-12)	College (1	1-4or 5+)	1	oo NOTuse n ege Pro	,				1	Educa	ation		
nd 2	e filed al Hygie I othar vant, II	BeC	17. Father's Name		ast)		1					e (First, Middl		Sumame	a)		
yla	2 should be fi and Mental H is markad ot sumatic eval	일	Thomas H				T					s Davi					
Ma	od 2 stath and 27 is not traum		19a. Informant's N Joanne M					<sub>ng Address (St</sub> Nayfair								Code)	
Baltimore,	Pages 1 and 2 nent of Health of Health sut: If item 27 ary or other tru		20a. Method of Dis 1 Burial 2 4 Donation	Cremation :	3 □ Removal from scify)	0	Place of Dispo	sition (Name of matory or other ce Crem	of r place	)	1	Date	20c. Lo	ocation - (	City or To		
Balti	Guerfillar 130 Speer Road, Cheste									n & Ne estert	wnam own,	Fune Mary	ral land	Home, 21620	o <sup>P.A.</sup>		
	Physician / Medical Examiner   Physician and physician and physician and the prival-transit	23a. Ant. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. CARDLO PULMON ARY ARREST  Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate  Due to (or as a consequence of):										Approximation Interval Betto Onset and I	ween Death				
P.O. Box 68	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funaral Diractor: Atter this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was deceden in the past 12 1 □ Yes 23 9 □ Unknown	months?	1 Live b	come of pregna pirth 2 ☐ Feta nant at time of d	I death 3	Ectopic pregn						23d. Date Mon	of delive	,	/ear
rds, P	w requires that been signed b should be deta	þ	Part II. Other signi	ficant condition	s contributing to de	eath but not res	ulting in the u	nderlying caus	e giver	n in Part I.				1		e cause of d	
il Records,	: The law re cate has bee page 2 sho	Completed			-						-	24a. Wa auto per 1  Yes	s an opsy ormed? 2 1 No	pr de	ior to con	esy findings and pletion of ca	available ause of
Vital	ysician: The is certificate hi director, page	o Be	25. Was case reference examiner?		Hospital:		FD(0		Other	,		Check only					
o 0	g Physical this neral di	n; To	27. Manner of Deal	th	28a. Date		28b. Time of		Injury a	4 🗆 1901		me 5 K Res 28d. Describe	idence how injur			)	
ivision	r Attending I ler death. ractor: After i by the funer	Certification;	1 Natural 2 Accident 3 Suicide 4 Homicide	5 Pending investiga 6 Could no determin	ot be 28e. Place	of Injury - At ho	Injury ome, farm, str	М	1 🗆 Y	es 2 🗆 N			(Street an		r or Rural	Route Numi	ber,
9	To the Hospital or Attent within 24 hours after deatl To the Funaral Diractor: completely filled in by the		29a. Certifier	1 Certifying	Physician: To the	best of my kno	wledge, deati	n occurred at th	he time	, date and	d place,	and due to the	cause(s)	and man	ner as sta	ated.	
	the Hi hin 24 the Fu	Medical	(Check only one)	2   Medical E	xaminer: On the b	asis of examina ner stated.	tion and/or in	vestigation, in r	my opii	nion, deat	h occurr	ed at the time	, date and	I place, ai	nd due to	the cause(s)	)
	To To Con	<	29b. Signal ore and	Little of Certifier	-120	~				number 706	7		29d. Dat	1	(Month, E	ay, Year)	
,			30. Name and addr			se of death (Item	n 23a) (Type,						_ 1 ]	<u>' l</u>			
			TOHN	J. 1	3 FERLA	mo	100	BRO	WN	7 5	5,0	HEST	ERT	DW M	in	921	620
	Sta Registr		31. Date filed (Mon	APR 1	1 2005 32. R	ecistrar's Signa	ature	And Es									

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ORIGINAL

<u>₹</u>		h with	व्याष्ट		519 Wellington (	Court			2170	3	
NORMAN	920	1 and 2 should be filed within 72 hours after death with Health and Mentał Hygiene. Inn 27 Is marked other then "natural", or lieme 23a oi	any Injury or other treumatic event, the Madical Examiner must be 2059.	by Funeral D	11. Marital Status  1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ev Armed Forces? 1  Yes 2 No If Yes, Give Year or Dates:		13. Was Deco		ispanic Origin? (S in, Mexican, Puerl Specify:	pecify Y to Rican,
8	5-0	72 ho	dical	eted	15. Decedent's (Specify only highest of	Education grade completed)	16a.	Decedent's Usi (Give kind of w	ual Occupa	ation during most of world)	rking
Z	121	within ene.	Ne Me	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	7	Fruck Dr		9)	
	9	filed Hygi	ent, 1	Be C	17. Father's Name (First, Middle, La	st)				18. Mother's Nar	πe (First
	<u>a</u>	lid be lental	ic ev	2 B	William Hahn					Glori	a Hi
	ary	should have	nme		19a. Informant's Name/Relationship	(Type, Print)	19b	. Mailing Addres	ss (Street a	and Number or Ru	ural Rout
	Σ	and 2	er tre		Margaret L. Hine	es / Wife		19 Welli		n Court	Fre
	Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours aft. Department of Health and Mental Hygiene.	ry or oth		20a. Method of Disposition  1   Burial 2 □ Cremation 3  4 □ Dopartion 5 □ Other (Spe		cemete	f Disposition (Na ry, crematory or livet Ce	other plac	Apr	il 6 200
	Balti	permit. Pages 1 Department of H	any Inju once.		21. Signature of Huneral Service Lic	ensee Cansee				ss of Facility St.	auff
	60,	Exan	dical niner	il Examiner	23a. Part1. Enter the disease, or conshock, or heart failure. List or immediate Cause (Final disease or condition resulting in death)  Esquantially list surdiffice if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last	a Due to (or a) a	consequence	of): S CLC	Pw.	lg, such as cardia Lu M (X)	or resp
	of Vital Records, P.O. Box 68760,	Physicien: The law requires that the death certificate be executed to and the continuous has been and the continuous has been and the continuous has been and the continuous has been and the continuous has been and the continuous has been and the continuous has been and the continuous has been and the continuous has been accounted as the conti	is certificate rias been signed by the anemoning programment director, page 2 should be detached for use as the burial-transit	Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at ti	Fetal death	n 3 ⊟Ectopic 5 ⊟ Other (		′	
	ords, P.	equires that	ould be detached	ted by Pr	Part II. Other significant condition	s contributing to death but	not resulting	in the underlying	cause giv	ren in Part I.	2
	3ec	mple mple		2 mill	111				2		
	a	To Mai die in in in in in in in in in in in in in				dical 26. Place of Death (Che					
	Ξ	25. Was case referred to medical examiner?				Hospital:	t 2 ERVO	utpatient 3 🗆 I	DOA Oth		
	of O	£ .	alo		27 Manner of Death	28a Date of Injury		Time of	28c Injur		28d. [

28a. Date of Injury (Month, Day Year)

1. Decedent's Name (First, Middle, Last)

Norman

5. Social Security Number

Usual Residence of Decedent

215-80-2580

10e. Street and Number

10a. State

Maryland

Eugene

Frederick Memorial Hospital

Frederick

6. Sex

4a. Facility Name (If not institution, give street and number)

10b, County

Hines

1⊠M 2□F

7. Age (In yrs. last birthday)

10c. City, Town or Location

Frederick

10f. Zip Code

41

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28e-f show notified at

State of Maryland / Department of Health and Mental Hygiene 2. Date of Death Month Day April 2005 9:12  $P^{M}$ 4c. County of Death Frederick 8. Date of Birth (Month, Day, Year) May 25, 19 Birthplace (State or Foreign Country) 1963 Maryland 10d. Inside City Limits 1 XYes 2 No 10g. Citizen of What Country? United States 14. Race - American Indian, Black, White, etc. Specify Yes or No-Specify: White 16b. Kind of Business/Industry Trucking ame (First, Middle, Maiden Sumame) ia Hines Rural Route Number, City or Town, State, Zip Code) Frederick, Maryland 21703 20c. Location - City or Town, State 2005 Frederick, Maryland tauffer Funeral Homes, P.A. Frederick, Maryland 21702 Approximate Interval Between ac or respiratory arrest, 23d. Date of delivery Month Year 23a. Did tobacco use contribute to the cause of death? 1 Yes 2 □ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1. Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

State Registrar

Medical Certification: To

5 Pending investigation

6 Could not be determined

27. Manner of Death

1 Natural

2 Accident

3 ☐ Suicide

29a. Certifier

4 - Homicide

(Check only one)

31. Date filed (Month

29b. Signature and title of certifier

Division of Vital

To the Hospitel or Attending Physicien: within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director. I

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

leted cause of death (Item 23a) (Type, Print)

28c. Injury at Work?

29c. License number

1 ☐ Yes 2 ☐ No

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Certificate of Death

4b. City, Town, or Location of Death

If Under 1 Year If Under 24 Hrs.

Months Days Hours Min.

Frederick

			1 - For State Registrar	State of M	Maryland /	•	artment of H		-	giene Reg. No. 2005	13948
	Dhusiei	210	1. Decedent's Name (First, Middle	, Last)	-				2. Date of De.	ath Day Year	3. Time of Death
	Physicia /Medic			WANDA I	ELAINE	НО	RNER		APRIL	9, 2005	5:30 A <sup>M</sup>
	Examin	er	4a. Facility Name (If not institution, CARROLL HOSP	•			4b. City, Town, or WESTM	Location of Dea	ath	4c. County of Dea CARR	
	Funeral Director		218-40-9604	6. Sex 7 1 ☐ M 2 ☑ F	Age (In yrs. last l	oirthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir		9. Bir y, Year) 9. A Bir 941 MAI	thplace (State or Foreign ountry) RYLAND
	land		Usual Residence of Decedent  10a. State 10b. County		10c. City, To	wn or Lo	cation				10d. Inside City Limits
	should be filed within 72 hours after deeth with the Maryland of Mental Hygiene. marked other than "natural," or itams 23a or 28a-f show imatic event, the Modical Examiner mat be notified at	Funeral Director	MD. CARRO	OLL				CANEYTO	NWO		1∭Yes 2□No
	with the or 2	Dir.	10e. Street and Number	DD			10f. Zip Code 2178	7		10g. Citizen of What Co USA	ountry?
	s 23	erai	75 CARNIVAL  11. Marital Status	12. Was Decede	nt Ever in U.S.	13.1			Specify Yes or No		erican Indian.
9	or item	/ Fun	1 ☐ Never Married 2 ☐ Marri	Armed Force	s?		Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2 HNo	Specify:	nto Rican, etc.)	Black, Whi	te, etc.
5-0036	urai',	d by	3 ☐ Widowed 4 ☒ Divorced	Year or Date	-	'a Dane					
5	n 72 l	iete	15. Decedent (Specify only highes	t grade completed)		(Give	tent's Usual Occup kind of work done o DO NOT use retired	during most of w	orking	16b. Kind of Business	Andustry
2121	iene. r thar	Completed	Elementary/Secondary (0-12)	College (1-4d	or 5+)		HOUSE	_		HOME MAR	KER
	be filed writel Hygie od other to	Be	17. Father's Name (First, Middle, I	*	W IIO	VD.				Maiden Sumame)	3D
yla	ould h	10		EWTON J.						NIA MILLE	
Maryland	d 2 sh th and th sn traun		19a. Informant's Name/Relationsh VERNON REDDIN							er, City or Town, State, FELTON, I	,
	tem 2		00- M-H-4-4-Di		20h Blaco	of Dispo	sition (Name of	!	Date	20c. Location - City or	
Ë	Pages nent of int: if i		1 Surial 2 □ Cremation  1 Donation 5 □ Other (Sp.	3 □Removal from Sta pecify)	"GRACE		natory or other place RCH CEM	4/1	1/05	COCKEYSVI	LLE, MD.
Baltimore,	permit. Pages 1 and 2 should be Depertment of Health and Menta importent: if item 27 is marked any injury or other traumatic ex		21. Signature of Funeral Service I	icensee	6					FUNERAL INSTER, M	
			23a. Part1. Enter the disease, or shock, or heart failure. List	only one cause on each	h line.						Approximate Interval Between Onset and Death
	Physician .		Immediate Cause (Final disease or condition resulting in death)	_a. Vont	ricelay	-	ibn'lles	TON			ely fair
	/Medical Examiner		, and the second	Due to (or	as a consequenc	e of):	cardio	Caperi	landi d	Rease	
		er	Sequentially list conditions, if any, leading to immediate	C. A. Service and Co.	as a consequenc		0000			2 0(	
	cuted nd ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c							
90,	ate be executed hysician and the burial-transit	i Ex	resulting in death) Last	Due to (or	as a consequenc	e of):					
68760,	icate t	dicai		d							
ox (	death certifica e attending ph od for use as th	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcor			-			23d. Date of de	livery
$\mathbf{\omega}$	e death the atte	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown		n 2 □ Fetal dea t at time of death n		Ectopic pregnancy Other (specify)	1		Month	Day Year
, P.O.	uires that the dei signed by the a Id be detached f	by Phy	Part II. Other significant condition	ns contributing to deat	h but not resulting	g in the u	nderlying cause giv	en in Part I.	23e. Did to	obacco use contribute to	the cause of death?
rds	w requires been sign should be								10	res 2□No 3□P	robably 4 Dunknown
Records,	S 5	Completed							24a. Was		utopsy findings available completion of cause of
œ.	The ate h page	Con							perfo	med? death? 2. No 1 ☐ Yes	
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			Oth	or.	eath (Check only o		
of	Phys r this ral dir	. To	1 ☐ Yes 2 ⚠ Xo  27. Manner of Death	28a. Date of l	niury 28t	Outpatier  o. Time o	it 3 DOA	4   Nursing	T	dence 6 Other (Spe	cify)
On	Attending ir death. ector: After by the fune	ation	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investig	(Month,	Day Year)	Injury	Wor	k? Yes 2□No		, , , , , , , , , , , , , , , , , , , ,	
Division	To the Hospitel or Attending Physician: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.	Certification:	3 Suicide 6 Could n 4 Homicide determi	ot be 28e. Place of	Injury - At home, etc. (Specify)	farm, str	eet, factory, office		28f. Location (S City or Tox	Street and Number or R	ural Route Number,
	Hospitel o		29a. Certifier 1 Certifyin	n Physician: To the b	act of my keoule	lan daasi	a negurad at the ti-	no data and al-	and due to the	cause(s) and manner a	etatod
	24 hc 24 hc e Fun letely	edical	(Check only 2 Medical I	Examiner: On the basis and manner	s of examination :	and/or in	vestigation, in my o	pinion, death oc	curred at the time,	date and place, and du	e to the cause(s)
	To the h within 24 To the f complete	Me	29b. Signature and title of certifier				29c. Licens			29d. Date signed (Moni	h, Day, Year)
	3		Olivacle	du Noge	2000-		Di	8100		4/11/0	5
	A D		30. Name and address of person of 7 OF A POP & Re		of death (Item 23a	a) (Type,	Print) J	1157	CHITA	411110 LACHEDY M	ACIANNA
. 2	Sta Registr		31. Date filed (Month, Day, Year) APR 1	32. Reg	istrar's Signature	he.	1				
	registi	uı	HEK T	T TOOM IN	STATE A	P 1	TO SHEET				

			For	Please						e All Copies ad Mental Hy		_egible.		
		•	1 - State Registrar				Cei	tificate of	Death		Reg. No."	005	139	49
	Physici /Medic	_	1. Decedent's Name (Fi		elyn	Hall				2. Date of De Month Apri	Day	200 <sup>Year</sup>	3. Time of D 9:00	Death P M
	Examir		4a. Facility Name (If not	institution, give	street and number)	)		4b. City, Town, o	or Location of E	Death	4c. (	County of Death		
			Solomons						Omons	Hea I		Calv		
	Funeral Director		5. Social Security Numb	620 1	0 × 27 F 7. Ag	ge (In yrs. Ia 63	Yrs.	If Under 1 Year Months Days		Min. 8. Date of Birt (Month, Da Sept 28	8, 19	9. Birth Cou West	place (State or I ntry) Virgin	Foreign nia
]	and and		Usual Residence of Dec 10a. State 10	b. County		10c. City,	Town or Lo	cation					10d. Inside City	/ Limits
	8a-fsh	Funeral Director		alvert					omons	· · · · · · · · · · · · · · · · · · ·			1 ☐ Yes 2	2 No
	a or 2	ă	10e. Street and Number					10f. Zip Code	0.0		-	en of What Cou	ntry?	
3	na 23	erai	13325 Dowe	ell Ra.	12. Was Decedent	Ever in U.S	. 13.1	2068 Was Decedent of h		? (Specify Yes or No		JSA 4. Race - Ameri	can Indian.	
936	nin 72 hours eiter deein wiin ine Maryland 3. "In "naturel", or itema 23a or 28a-f show Madical Examiner must be notified al	ğ	1 Never Married 3 ☐ Widowed 4 ☐		Armed Forces?  1 ☐ Yes 2X☐ If Yes, Give Year or Dates:	?		fYes, specify Cub 1 ☐ Yes 21X1 No		n? (Specify Yes or No Puerto Rican, etc.)		Black, White,		
က်	n "nai	Completed	(Specify o	Decedent's Ed	de completed)	F.)	(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of	f working	16b. Kin	d of Business/In		
717	M C C C	mo	Elementary/Secondar	ry (0-12)	College (1-4or		posta	l worker			U.S.	Postal	Servi	ce
		Be C	17. Father's Name (Firs	t, Middle, Last)			-		18. Mother's	Name (First, Middle,	Maiden S	Sumame)		
<u>a</u>		은	Conley W	/illiam_	Hall				Annie	Caroline		Sturdiva		
Mary	s 1 and 2 shou f Health and M Item 27 ie mar other traumat		19a. Informant's Name							or Rural Route Number			Code)	
_	f Health item 27 other tra		Willard C.  20a. Method of Disposit		brother	20h Pla		Garner Av		aldori, M		0602 cation - City or To	Ctata	
altimore,			1 ⊠ Burial 2 □ Ci	remation 3 🗆	Removal from State	'		sition (Name of natory or other pla	_ '					
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ñ	Ded in personal		ווו אוני	am R	CA.				189407	Home, P.A		wings,	MD 207	736
	A.F.		23a. Part1. Enter the d	isease, or compilure. List only	olications hat cause one cause on each li	d the death.							Approximate Interval Betwee Onset and De	99 <i>n</i>
F	hysician /Medical		disease or condition resulting in death)	-	a Due to (or as	220	cas	2 1	V Lyg	lopale	7	- 1	20 y	pen
E	Examiner				Due to (01 as	a conseque	silos oi).		U	` (	1		Ú	j
	D H	ner	Sequentially list conditi if any, leading to immediate. Enter Underlyin Cause (Disease or injur	ons, diate	Due to (or as	а сопънци	anica di).				V			
	eath certificate be executed attending physicien and for use as the burial-transit	Examiner	Cause (Disease or injuit that initiated events resulting in death) Last	ý	c. Due to (or as	2 00000000	anno of):							
ָסֶׁ פַּ	icien burial	aiE			D00 (0 (0) as	a conseque	siles oi).							
289	phys s the				. d									
XON	death certificate e attending phys od for use as the	n/M	IF FEMALE: 23b. Was decedent pre	gnant	23c. If yes, outcome			Je			20	3d. Date of delive	ary	
n O	0 0	Physician/Medic	in the past 12 mor 1 ☐ Yes 2 ☐ You 9 ☐ Unknown		1□Live birth 4□Pregnant a 9□Unknown			Ectopic pregnancy Other (specify)	у			Month	Day Ye	ar
J	I ne law requires that the te has been signed by th page 2 should be detache	by Pt	Part II. Other significar	t conditions c	ontributing to dea	ut not resul	ting in the u	nderlying cause giv	en in Part I.	23e. Did to	obacco s	e contribute to t	ne cause of dea	ath?
Hecords,	w requires been sig should by		D Se	- m	L 0	15	ov d			101	res 2	o Prot	oabiy 4 □Uni	iknown
ဝ ၁	as be 2 sho	Het	2) A)	me		le	lev			24a. Was autop	an	24b. Were auto	psy findings av	/ailable
ř,	ate ha	Completed	(3) Co	nest	Ži ve	Dla	art.	Ta	ilene	perfor 1 ☐ Yes	rmed?	death?	2□ No	736 01
Vital	entific sctor.	Be (	25. Was case referred examiner?	to medical						Death (Check only o	ne)			
01	this c	P	1 ☐ Yes 2 ☐ NO		Hospital: 1 Inpati	-	R/Outpatien			ng Home 5 Resid			v)	
ם	After After funer	ertification:		☐ Pending investigation	28a. Date of Inju (Month, Da	y Year)	28b. Time of Injury	Wor	rk? ∣Yes 2. □No	28d. Describe h	10W Injury	occurred		
DIVISION	deat deat ctor:	fica		Could not be determined	28e. Place of In		ne, farm, str	eet, factory, office	100 2 2.10	28f. Location (S		Number or Rura	ıl Route Numbe	a <i>r</i> ,
	s after	Cert	4 Homicide	/	building, e	tc. (Specify)				City or Tow	vn, State)			
:	To the Nobrital of Attending Physician: The law within 24 hours after death.  To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2.	edicai (	29a. Certifier (Check only one)	Certifying Ph Medical Exam	ysician: To the best niner: On the basis of and manner st	of examination	rledge, death on and/or in	occurred at the tild vestigation, in my o	me, date and p opinion, death	place, and due to the o occurred at the time, o	cause(s) a date and p	and manner as s place, and due to	ated. the cause(s)	
1	Vithir To th comp	Me	29b. Signature and title	of certifier	2 2	, M	1)	29c. Licens		7	29d. Date	algned (Month,	Day, Year)	
1			PH	1	YULLA	0,6	thysi	ال نـ	194	A /	4	11/19	,05	
	1.		30. Name and address			death Item	23а) Дурв.	Print)	OD P	enes Fre	do	K M.	D2067	18
	0			MUN Day Kearl		s Signatu		01070	A DO					
	Sta Registi	-	31. Date filed (Month, E	APR 1	2 2005	s Signatu	K	brack ,						

2644		1- State of Maryland / Der Megistrar  1- Registrar  1- Registrar		-	•					
Physic	ian	1. Decedent's Name (First, Middle, Last) Roger Joseph Hall	Dertificate of Death	2. Date of Death Month	Day Year OF25					
/Medi Exami		4a. Facility Name (If not institution, give street and number) Anne Arundel Medical Center	4b. City, Town, or Location of Death Annapolis	April 1	4c. County of Death Anne Arundel					
Funeral Director		5. Social Security Number  220-56-7615  Usual Residence of Decedent  6. Sex  7. Age (In yrs. last birthe	day) If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, ) June 15,	Year) 9. Birthplace (State or Ficulty) 1951 Maryland	oreign				
Maryland a-f show	tor	10a. State 10b. County 10c. City, Town of Maryland Anne Arundel	Annapolis		10d. Inside City L 1 ☐ Yes 2x					
th with the 23a or 28 Ist be not	ai Director	10e. Street and Number 1205 Southview Drive	10f. Zip Code 21401	100	10g. Citizen of What Country? U.S.A.					
ING Z1Z13-UU30 be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or items 23a or 28a-f show event, the Modical Evertirer must be notified at	by Funeral	11. Marital Status  1 Never Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes 275No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerton Tollows)     Toldows	pecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: White					
C Z I Z I 3-U	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)  12	ecedent's Usual Occupation Give kind of work done during most of work fie. DO NOT use retired)  Salesperson	king 16	Sb. Kind of Business/Industry  Retail					
	To Be Co	17. Father's Name (First, Middle, Last) Charles Leroy Hall	18. Mother's Nam	's Name (First, Middle, Maiden Sumame) Helen Mae Paulman						
			Mailing Address (Street and Number or Rui D5 Southview Drive		City or Town, State, Zip Code) S, Maryland 21401					
Saltimore, I bermit. Pages 1 and Department of Health mportant: If item 2 any injury or other and		T D donar 2 (A Oremation 3 (D) temovarion office	Disposition (Name of crematory or other place)  Dre Crematory 4/18	40.0	c. Location - City or Town, State Baltimore, Marylan	nd				
Dattimory permit. Pages Department of t Important; if ite any injury or of once.		21. Signature Funeral/Senice Licensee	22. Name and Address of Facility Joh 147 Duke of Glouces	n M. Tay	lor Funeral Home					
Physician /Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Adrenal Glands  Due to (or as a consequence of	Infarcts	or respiratory arres	t, Approximate Interval Betwee Onset and Dea					
filcate be executed filcate be executed filcate be executed by physician and the burial-transit filcate burial-transit filcate	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):								
ath cert	Physician/Medica	d.  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \Boxedownerrow version in the past 12 months? 9 \Boxedownerrow version version in the past 12 months? 1 \Boxedownerrow version vers	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month Day Year					
COTGS, P.O. I	þ	Part II. Other significant conditions contributing to death but not resulting in t	he underlying cause given in Part I.	1	cco use contribute to the cause of deat 2 □ No 3 □ Probably 4 ☑Unk					
	Completed			24a. Was an autopsy performe 1 Ves 2		allable se of				
LIVISION OT VITAI HE INTERIOR OF VITAI HE IT TO THE HOSPITAL OF Attending Physician: The It within 24 hours after death.  To the Funeral Director: After this certificate hat completely filled in by the funeral director, page 2	ation: To Be	25. Was case referred to medical examiner?  12 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation  28a. Date of Injury (Month, Day Year)	patient 3 DOA Other: 4 Nursing H	th (Check only one) ome 5 Residen 28d. Describe how	ce 6 □Other (Specify) injury occurred					
DIVISION  To the Hospital or Attent within 24 hours after deatt To the Funeral Director: completely filled in by the	Certification:	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm building, etc. (Specify)	n, street, factory, office	28f. Location (Stre City or Town,	et and Number or Rural Route Number State)	r,				
Lothe Hospital within 24 hours a Tothe Funeral to	Medical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, 2 Medical Examiner: On the basis of examination and manner stated.	death occurred at the time, date and place for investigation, in my opinion, death occu	and due to the cau red at the time, dat	se(s) and manner as stated. e and place, and due to the cause(s)					
To t withi To ti	Σ	29b. Signature and title of certifier	29c. License number OCME	290 A	Date signed (Month, Day, Year) pril 16, 2005					
1 1 2 2		30. Name and address of person who completed cause of death (Item 23a) (T	ype, Print) 111 Penn Stre	et Balti	more, Maryland 212	201				
S Regis	tate trar	31. Date filed (Month, Day, Year)  32. Registrar's Signature	South							

021	0//		State of Maryland / Dena					
			1- For Unpend Item 23a,27,28a-f per me Registrar	G843 5-12-05 tas rtificate of Death	Reg	7.005	3951	
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Barbara Ann Highlands		2. Date of Death April 16	5, Day 2005 Yeer	3. Time of Death 14:30p M	
	Examir		4a. Facility Name (If not institution, give street and number) 12040 Big Pool Road	4b. City, Town, or Location of Death Clear Springs		4c. County of Death Washingtor	1	
	Funeral Director		5. Social Security Number 8 6. Sex 7. Age (In yrs. last birthday) 1 □ M 2 ▼ F 4 5 Yrs.	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, ) Mar 7,	Q Dist	lace (State or Foreign	
	D		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Lo	ocation	1101 , ,		0d. Inside City Limits	
	the Many 28e-f sh ctiffied	Director	MD Washington Clear S	7	100	Citizen of Miles Cours	1 □Yes Ž□No	
	23a or		12040 Big Pool Rd.	10f. Zip Code 21722		g. Citizen of What Cour	itr <b>y</b> ?	
980	72 hours after death with the Maryland "netural", or Items 23a or 28e-f show office Exeminer must be notified at	by Funeral	1 Never Married 2 Married 1 Yes 2 YNo	Was Decedent of Hispanic Origin? (Spo If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☑ No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify: Whi	etc.	
21215-0036	within ene. than "	Completed	(Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of work DO NOT use retired) DMEMAKET	ing 16	16b. Kind of Business/Industry residence		
Maryland 2		To Be C	17. Father's Name (First, Middle, Last) Larry Highlands Sr.	France	s Shear	er		
	W = m =		19a. Informant's Name/Relationship (Type, Print)  Rob Smith fiance  1204	ng Address (Street and Number or Rura 10 Big Pool Rd.	Clear :	City or Town, State, Zip Spring, M	Code) D 21722	
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any Injury or other tra <u>once</u> .		20a. Method of Disposition  1 XBurial 2 Cremation 3 Removal from State  1 Donation 5 Other (Specify)	esition (Name of April <sup>©</sup> matrix of other place) April <sup>©</sup> 1 Cemetery 200		Big Pool,		
Balti	permit. Departr Importe any Inji		21. Signature of F Ineral Service Letters 2	Name and Address of Facility The Donald Edwin The P.O.Box 310 Clea	ompson l	Funeral H	ome Inc	
	Physician :		23a. Part. Enter the disease, or complications that caused the death. Do not entend shock, or heart allure. List only one cause on each line.  Immediate Cause (Final disease or condition a Combined Tramadol	er the mode of dying, such as cardiac of	or respiratory arres	t,	Approximate Interval Between Onset and Death	
,092	Medical Examiner  percented price an	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Early Underflying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):					
O. Box 68	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medic		□Ectopic pregnancy □ Other (specify)		23d. Date of delive Month	ry Day Year	
rds, P.	quires that n signed b ild be deta	by	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.	23e. Did toba	cco use contribute to th	e cause of death? ably 4  Unknown	
al Records,	ian: The law require rriticate has been sig ctor, page 2 should b	Completed			24a. Was an autopsy performe	prior to con death2	osy findings available inpletion of cause of	
of Vital	Phyaician: this certific al director,	To Be	25. Was case referred to medical examiner?  1X Yes 2 No Hospital: 1 Inpatient 2 EP/Outpatien			ce 6X Other (Specify	At Scene	
Division o	Hospital or Attanding Physician: 4 hours after death. Funaral Director: After this certificately filled in by the funeral director,	Certification;	27. Manner of Death  1 Natural  2 Nacident  3 Suicide  6 Could not be	Mork? 1 ☐ Yes 2 No	28d. Describe how	injury occurred U	nk	
Divi	ital or Att rs after d al Direct led in by 1	Certifi	3 ☐ Suicide 4 ☐ Homicide  3 ☐ Suicide 4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  5 ☐ Gould not be determined building, etc. (Specify)  Found: Residence	eet, factory, office	28f. Location (Streen City or Town, 1	et and Number or Rura State) 12040 B ngs,Washing	ig Pool Rd. tonCo.,MD	
	To the Hospital within 24 hours at To the Funaral D completely filled i	Medical	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, deat and the basis of examination and/or in and manner stated.	h occurred at the time, date and place, a vestigation, in my opinion, death occurr	and due to the caused at the time, date	se(s) and manner as st a and place, and due to	ated. the cause(s)	
•	To the within 2 To the comple	Σ	29b. Signature and title of certifier  Maying The Yall My	29c. License number OCME	100	Date signed (Month, 1)		
51	1-0		30 Name and address of person who completed cause of death (Item 23a) (Type, HAWADAD)	111 Penn Stre	et Balt	imore, Mary	land 21201	
1.6	Sta Regist	- 100	31. Date filed Month, Par Year) 1 2005 32. Registrar's Signature	nails				

			1 - State of Marylan		partment of He			iene 05	13952
Ï			Decedent's Name (First, Middle, Last)				2. Date of Dear	th _	3. Time of Death
	Physicia /Medic		JOHN HUBERT	HI	CKEY		ADY!	Day 2005	5 1:10 PM
	Examin	er	4a. Facility Name (If not institution, give street and number)  Washington County Hospita	7	4b. City, Town, or L		1	4c. County of Dea	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs.		Hager	if Under 24 Hrs.	8. Date of Birth		ington
	Director		217-32-6038 <sup>10</sup> X <sup>M 2□ F</sup> 69	Yrs.	Months Days	Hours Min.	January	Year) C	rthplace (State or Foreign ountry) Maryland
	pug *_		Usual Residence of Decedent  10a. State 10b. County 10c. City	y, Town or	Location				10d. Inside City Limits
	Maryli fied a	ō	· ·		rstown				1 ☐ Yes 2 X No
	r 28a	irec	10e. Street and Number		10f. Zip Code		1	0g. Citizen of What C	country?
	23a c	raiD	2011 Maplewood Drive		217			U.S.	Α.
2020	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatin and Mental Hygiene. Department of Heatin and Mental Hygiene. Important: If team 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic svant, I're Medical Examiner must be notified at once.	by Funeral Directo	11. Marital Status  1 X Never Married 2 Married 3 Widowed 4 Divorced  12. Was Decedent Ever in U. Armed Forces? 11 Yes 2 No If Yes, Give 19 58	s. 13	<ol> <li>Was Decedent of Hisp If Yes, specify Cuban,</li> <li>1 ☐ Yes</li></ol>	panic Origin? (Spe Mexican, Puerto Specify:	cify Yes or No- Rican, etc.)	14. Race - Am Black, Whi Specify:	
5	72 hou	ted	15. Decedent's Education (Specify only highest grade completed)	16a De	cedent's Usual Occupati	ion		16b. Kind of Business	s/Industry
7	ithin 7	Completed	Elementary/Secondary (0-12) College (1-4or 5+)		ive kind of work done due  a. DO NOT use retired)			II C D	L-1 C
7	iled w Hygier Iher th	Co	12 17. Father's Name (First, Middle, Last)		Mail Carr			U.S. POS Maiden Sumame)	tal Service
2	Id be tental better was	To Be	John Francis	Hic		Mary		.eoada	Baughman
Mary	and M s mar	-	19a. Informant's Name/Relationship (Type, Print)	19b. Ma	ailing Address (Street an	d Number or Rura	l Route Number	, City or Town, State,	Zip Code)
 E	and 2 ealth a m 27 is		Minkey B. Cogan Cousin		East Irvin				
5	Pages 1 nent of H int: If Iter iry or oth				sposition (Name of crematory or other place)			20c. Location - City o	
altimor	it. Pa intmen intmen intent: injury		' 4 ☐ Donation 5 ☐ Other (Specify) Hags  21. Signature of Funeral Service Licensee		wn Cremator	- 1			, Maryland
Ö	permit. Departimport. any inj		D. R. hoel brady		Andrew K. C 40 East Ant	öffman F ietam St	uneral   reet. H	Home, Inc.	Md. 21740
			23a. Part1. Enter the disease, or complication, hat caused the death shock, or heart failure. List only one call to on each line.						Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	eps	in				Onset and Death
	/Medical Examiner		resulting in death)  Due to (or as a consequence of the consequence of	uence of):		•			2105
		er	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence)	uenea of):	ar can	1000	e		102
	cuted bd ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.						
Ď,	cate be executed physician and the burial-transit	I Ex	resulting in death) Last Due to (or as a consequence of the consequenc	uence of):					
20/00	certificate be executed nding physician and use as the burial-transit	dical	d						
XO	w requires that the death certific been signed by the attending f should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregna		_			23d. Date of de	alivery
0	death le atten ed for u	icia	in the past 12 menths?  1 Yes 2 No  1 Live birth 2 Feta		3 □Ectopic pregnancy 5 □ Other (s <i>pecify)</i>			Month	Day Year
7. 5	at the	Phys	9 Onknown						
Ś	requires that the reen signed by th hould be detache	by	Part II. Other significant conditions contributing to death but not res	-	e underlying cause given	in Part I. Nymer		bacco use contribute t es 2 □ No 3 □ P	to the cause of death?  Trobably 4 Unknown
Records	w requ	etec	Ingraemma . DVT	-		1	24a. Was a		
	sician: The law is certificate has bi	Completed					autops perforr	ned?   death?	utopsy findings available completion of cause of s
N II I		Be C	25. Was case referred to medical examiner?			26. Place of Death	1 ☐ Yes .; (Check only on		5 2 100
<u> </u>	Physician: this certific ral director,	은	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpat		4   Nursing nor		ence 6 Other (Spe	ecify)
	ding F h. After funera	tion:	27. Manner of Death    Natural   Simple   Pending   (Month, Day Year)	28b. Time Injur	y Work?	at es 2 □ No	28d. Describe ho	ow injury occurred	
DIVISION	Atten	ifica	3 Suicide 6 Could not be determined 28e. Place of Injury - At ho					reet and Number or R	iural Route Number.
5	talor s afte al Dir	Certification;	4 Homicide building, etc. (Specify	″			City or Towr	n, State)	
	To the Hospital or Attending Phys within & hours after death.  To the Funeral Director: After this completely filled in by the funeral directors.	edical	29a. Certifier (Check only one)  Certifying Physician: To the best of my kno 2 Medicel Exeminer: On the basis of examina and manner stated.	wledge, de tion and/or	eath occurred at the time r investigation, in my opin	, date and place, a nion, death occurre	and due to the ca ed at the time, d	ause(s) and manner a ate and place, and du	s stated. e to the cause(s)
	To t To t	Σ	29b. Signature and title of certifier		29c. License r	_	2	9d. Date signed (Mon	th, Day, Year)
			( Visa)		D62	1327	all of the same of	4/14/	v >
51	6-10+1		30. Name and address of person who completed cause of death (Iten Manzar Shafi 368 Mill		oe.Print) reet, Hage	erstown	. Marv	land 217	40
ر ر ا	Sta	ate	31. Date filed (Month, Pay Year) 32. Registrar's Signa				,		
	Registi		APR 1 & 2000	13. p	speciel				

		-	For State Registrar	State of Mar	•	rtment of H			ne 005	13953			
	Physicia		1. Decedent's Name (First, Middle, Las		11-11			2. Date of Death Month	Day Year	3. Time of Death			
	/Medic	al	Charles  4a. Facility Name (If not institution, give	Ridgely	HOTI	yday  4b. City, Town, or	Location of Death	April 13	4c. County of Dea	10:00a.M			
	Examin	er	1100 The Terrace			-	rstown		Washing				
	Funeral Director		212-30-0487		(In yrs. last birthday) 9 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y Oct.6,19	ear) C	thplace (State or Foreign puntry) Ltimore			
	and	-	Usual Residence of Decedent  10a. State 10b. County	1	IOc. City, Town or Lo	cation				10d, Inside City Limits			
	Maryl	tor	Maryland Washin	gton	Hager	stown				1 Yes 2 No			
	th the	irec	10e. Street and Number			10f. Zip Code		10g	. Citizen of What Co	ountry?			
	ath wi	rai	1100 The Terrace			21740			USA				
36	be filed within 72 hours after death with the Maryland hal Hygiene. Ida Hygiene. Ida dther than "neturel", or tems 23e or 28e-f show svent. I've Medical Evanimer must be rolliked at	by Funeral Director	11. Marital Status  1 □ Never Married 2X Married  3 □ Widowed 4 □ Divorced	12. Was Decedent Evenue Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	1	Vas Decedent of Hi f Yes, specify Cuba I ☐ Yes 2☐No	spanic Origin? (Sin, Mexican, Puert	pecify Yes or No- p Rican, etc.)	14. Race - Ame Black, Whi	te, etc.			
2-0	72 hou	sted	15. Decedent's Ec			lent's Usual Occupa			b. Kind of Business	/Industry			
121	within iene. than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. I	OO NOT use retired			electrica	1 sunn1v			
d 2	e filed v il Hygie other t vent. L	e Co	17. Father's Name (First, Middle, Last)	4		manager	18. Mother's Nan	ne (First, Middle, Ma	· · · · · · · · · · · · · · · · · · ·	г зарриј			
lan	lid be tental rked o	To B	Milton Richie	Hollyday			Jane	Keyes					
Maryland 21215-0036	2 should be f and Mental F Is marked of reumatic sver	. 8	19a. Informant's Name/Relationship (	•				ral Route Number, C	•				
e, r	of Health item 27 I		Scott Smyth - nepl 20a. Method of Disposition	iew	20b. Place of Dispo	sition (Name of			c. Location - City or				
nor	ages ant of it: If it y or o		1 ☐ Burial 2 ☐ Cremation 3 ☐  '4 ☐ Donation 5 ☐ Other (Specify		Hagerstow	natory or other plac	. / / 1	- 10-	·	, Maryland			
Baltimore,	permit. Pages 1 and 2 should by Department of Health and Menta Importent: If item 27 Is marked eny injury or other treumatic st		21. Signalar of Funeral Service Licer	F4	22	. Name and Addres	s of Facility M	INNICH FUN	NERAL HOM	E			
-			23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										
	Pnysician	i U	Immediate Cause (Final disease or condition	isease or condition CONLACT GUNSHOT WOUND TO READ									
	/Medical Examiner		resulting in death)	Due to (or as a	consequence of):								
		le.	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	consequence of):				= = = = = = = = = = = = = = = = = = = =				
	cuted nd transit	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events	C									
8760,	cate be executed oblysician and the burial-transit	ai Ex	resulting in death) Last	Due to (or as a	consequence of):								
687	licate l physi s the b	edicai		d									
O. Box (	The law requires that the death certific to has been signed by the attending p tage 2 should be detached for use as:	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at tir 9 ☐ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year			
Δ.	es that igned b	by Pt	Part II. Other significant conditions of	ontributing to death but	not resulting in the u	nderlying cause give	en in Part I.			o the cause of death?			
ecords,	v require been sig should b							1 Tes	2 <sup>2</sup> No 3□P	robably 4 Unknown			
$\alpha$	(G CT	Completed						24a. Was an autopsy performe	prior to death?	utopsy findings available completion of cause of			
Vital	Phyeicien: T this certificat ral director, pa	o Be	25. Was case referred to medical examiner?	Hospital:	0 □ ED/0 · · · ·	othe Othe		th (Check only one)	a 🗆 Ou /a	4.			
of			1 ☑ Yes 2 ☐ No  27. Manner of Death	1 ☐ Inpatient	28b. Time of	28c. Injun	4 □ Nursing ⊓	ome 5 🔀 Resident 28d. Describe how		ecity)			
ion	Attending F r death: actor: After by the funer	atio	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	1 23 03	10:00	a. <sup>M</sup> <sup>1</sup> □	Yes 2 🖾 No	Contact	gunshot w	ound to head			
27. Manner of Death 1						<sup>State)</sup> 1100 Ţl	ne Terrace						
	To the Hospitel or A within 24 hours after To the Funeral Dira completely filled in b	edicai		y <b>sician:</b> To the best of niner: On the basis of e and manner state	xamination and/or in								
	To th withir To th comp	Me	29b. Signature and title of certifier	0-1/		29c. Licenso D010		290	Date signed (Mon				
				Ditto			02		April 1	+, 2005			
1	H-10		30. Name and address of person who Dr. Edward W. Dit	to, III, 1	9011 Orcha	ard Terra	ce Rd.,	Hagerstown	n, Md. 21	742			
	Sta Regista		31. Date filed (Month, Day, Year) APR 15 2	005 32. Registrar	's Signature	rede							

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien@ [] [] 5 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Charlotte: Viola Marie HART 2005 20 pru 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Hagerstown Washington Washington County Hospital If Under 1 Year If Under 24 Hrs. Months Days Hours Min. (Month, Day, Year) Aug. 17, 1927 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) Months 1 □ M 2 🖾 F 77 Yrs. 212-24-3206 Maryland Usual Residence of Decedent 10c. City. Town or Location 10a. State 10b. County 10d. Inside City Limits 1X Yes 2 No Hagerstown Maryland Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 821 Washington Avenue 21740 USA 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 No 1 ☐ Never Married 2 Married white 1 ☐ Yes 2 No Specify: Specify. 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) supervisor cleaning state hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Ada Pearl Long William Pendleton Hovermale Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ronald L. Hart - son 1417 Salem Avenue, Hagerstown, Md. 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Cedar Lawn Mem. Park 4-16-05 Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Fuperal Service Licenses MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) AMOXIC uncephal Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Litter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? EMINTS COM A CARDHIC FEHAL 1 Yes 2 No 3 Probably 4 Onknown MYPERTEN SON 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an 1□ Yes 2☑No

Physician /Medical Examiner

physician

the

requires that the death certificate be executed

Physician:

this

Division of Vital Records, P.O. Box 68760,

permit. Page Department of Importent: If any injury or once.

**Physician** 

/Medical

Examiner

**Funeral** 

Director

r Items 23a or 286-f show uner yest be notified at

Pages 1 and 2 should be filed within 72 hours after death with to not of Heatth and Mental Hygiene.

nt: If item 27 is marked other then "natural", or Items 23a or 2

Baltimore, Maryland 21215-0036

Director

Funeral

þ

Completed

the Maryland

Examiner burial-transit Physician/Medical the þ Completed

IF FEMALE: 25. Was case referred to medical 1 ☐ Yes 2 ☐ No

1 Natural

2 Accident

3 🔲 Suicide

4 Homicide

29a. Certifier (Check only one)

Certification:

27. Manner of Death

To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After

State Registrar

3012100 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

5 Pending

investigation

6 Could not be determined

MD

28a. Date of Injury (Month, Day Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 368 mi 32. Registrar's Signature

D 62327

1 ☐ Yes 2 ☐ No

28c. Injury at Work?

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

05

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Hry. Md 21740

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

1 Inpatient 2 ER/Outpatient 3 DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

			For State Registrar	State of M	aryland / Depa	artment of H			giene Reg. No.?	75 100	grow grow
			Decedent's Name (First, Middle, Las	t)				2. Date of Dea	ath	3. Time of D	èath
	Physici: /Medic		RUTH E.	HAHN	·			Month	Day /O	Year 164	O M
	Examin	S. 1. 2		CE ATTI	HE LAKE	4b. City, Town, or SAUS	BURY			OMICO	
	Funeral Director		5. Social Security Number  221–18–4006  Usual Residence of Decedent	7. A	ge (In yrs. last birthday) 74 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da 8-3-19	y, Year) 30	9. Birthplace (State or Country) NEW JERSEY	Foreign
	yland		10a. State 10b. County		10c. City, Town or Li	ocation	-			10d. Inside City	Limits
	e Mar	ctor	DELAWARE SUSSEX		LEWES					1X Yes 2	2 🗌 No
	ier death with the Marylan Items 23a or 28a-f show Item institued at	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of W	hat Country?	
	ss 23s	erai	40 CLAY ROAD	12. Was Decedent	Ever in U.S. 13	19958 Was Decedent of His	spanic Origin? (St	acify Yes or No	US 14 Bace	- American Indian,	
21215-0036	a o	by Funerai	1 ☐ Never Married 2 ☐ Married 3 🏋 Widowed 4 ☐ Divorced	Armed Forces  1  Yes 2 X  If Yes, Give  Year or Dates:	? No	If Yes, specify Cubai	Specify:	Rican, etc.)		k, White, etc.	
2-0	72 hours 'natural', dical Ex.	Completed	15. Decedent's Ed (Specify only highest gra		(Give	dent's Usual Occupa	luring most of won	king	16b. Kind of Bu	siness/Industry	
121	I within 72 ho iene r than "natur the Madical	mpl	Elementary/Secondary (0-12)	College (1-4or	5+) life.	DO NOT use retired,	)		DECEALIT		
d 2	Hyg the int,	e Co	17. Father's Name (First, Middle, Last)		WAL	TRESS	18. Mother's Nam	ne (First, Middle,	RESTAUR Maiden Sumam		
lan	od at b	To B	CLARENCE D. NEWC	OMB			BUENA E	. RIGGI	NS		
Maryland	d 2 should th and Men 7 is marke traumatic		19a. Informant's Name/Relationship (7	ype, Print)	19b. Maili	ng Address (Street a	and Number or Ru	ral Route Numbe	er, City or Town,	State, Zip Code)	
	an m 2 ne		THEODORE POLITE/	SON		SCHOOL LA	NE, MILI				
Baltimore,	of of		20a. Method of Disposition 1 □ Burial 2 X Cremation 3 □		20b. Place of Dispo	matory or other place NLOPEN	9)	Date		City or Town, State	
Itim			*4 □ Donation 5 □ Other (Specify 21. Signatule of Funeral Strvice Light		CREMATOR	RY	4-12			RD, DELAWAI	RE
Ba	permit. Departr Imports any inju		1 thouse	Melan	M)	2. Name and Addres ELSON FUNE DNG NECK R	RAL SERV	ICES, LT	D. 19966		
3			23a. Part 1. Enter the disease, or com shock, or heart failure. List only	olications that cause one cause on each						Approximate Interval Between	
8	Enysician		Immediate Cause (Final disease or condition	Cho	- Obsta	Fire 1	Lu l	) Same		Onset and De	eath
	/Medical Examiner		resulting in death)	Due to (or as	s a consequence of):		0	10. <del>- 6.</del>		7.0	•
		e e	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	s a consequence of):						
	uted d ansit	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events	C							
o,	an an	Exa	resulting in death) Last		a consequence of):						
8760,	cate be executed oblysician and the burial-transit	dicai		d							
Вох 6	eath certific attending p	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 19 mpnths?		2 ☐ Fetal death 3	□Ectopic pregnancy			23d. Date Mor	e of delivery	ar
0	that the de led by the a detached t	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	at time of death 5 [	Other (specify)					
ds, P	luires that signed b Ild be deta	by	Part II. Other significant conditions of	ontributing to death	but not resulting in the t	underlying cause give	on in Part I.		,	ibute to the cause of dead	
Records,	The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Completed						24a. Was autop perfo	osy p neged? d	Vere autopsy findings avrior to completion of cau	vailable use of
Vital	ysician: Th is certificate director, pag	BeC	25. Was case referred to medical examiner?				26. Place of Dea	th (Check only o	ne)		
of \	S S	2	1 ☐ Yes 2 No  27. Manner of Death	Hospital: 1 Impat 28a. Date of Inj			4 Nursing H		dence 6 Othe		
	ding I h. After funer	tion	Natural 5 Pending	(Month, D	ay Year) Injury	Work	(? Yes 2 □ No	20d. Describe i	low injury occurre	<del>-</del>	
Division	or Attending after death. Director: After in by the fune	ifica	3 Suicide 6 Could not b		njury - At home, farm, st tc. (Specify)	reet, factory, office				ar or Rural Route Numbe	er,
Ö	s after al Dire	Certification:	4 Homicide determined	building, e	тс. (Ѕреспу)			City or Tov	vn, State)		
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical	29a. Certifier (Check only one) Certifying Ph	ysician: To the bes niner: On the basis and manner s	t of my knowledge, dea of examination and/or in tated.	th occurred at the time envestigation, in my op	e, date and place pinion, death occu	, and due to the rred at the time,	cause(s) and mad date and place, a	nner as stated. and due to the cause(s)	
)	To the within To the Comple	M	295. Signature and title of certifier	00	PMS	29c. License	number 2627	8	29d. Date signed	(Month, Day, Year)	
Ci	42		30. Name and address of person who	completed cause	eath (Item 23a) (Type	, Print)	Rx 17	72 (	1.1	WA 2/5	0 4
¥	SI	ate	31. Date filed (Month Dayb Year)	32. B	trar's Signature	you.	0-110	J U	DITS	0.0 00	
p.	Regist		31. Date filed (Month Alex) 1947) 3	2005	in & g	hade					

			For State of Ma		artment of Heal		ntal Hygie	4000	13956				
			Decedent's Name (First, Middle, Last)				Date of Death		3. Time of Death				
	Physicia /Medic		John Hutnick			Ap	oril 7,	2005 Year	6:00 A. M				
	Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Loca	ation of Death		4c. County of Death					
			Charlotte Hall Veterans Home		Charlotte			St. Mary's	5				
	Funeral Director		5. Social Security Number 6. Sex 7. Age 17. Age 7.	(In yrs. last birthday) Yrs.		Jnder 24 Hrs. 8. I ours Min. Au	Date of Birth Month, Day, Ye	9. Birth Cou 1926 Penns	place (State or Foreign ntry) Sylvania				
	pu ,		Usual Residence of Decedent	10-01-7									
	aryla ehov	12	10a. State 10b. County	10c. City, Town or Lo					10d. Inside City Limits				
	he M	ecto	Maryland Calvert	Prince Fr				077	1 □Yes 2□No				
	a or	Funerai Director	10e. Street and Number 4301 Cassell Blvd.		10f. Zip Code 20678			citizen of What Cou	_				
	leath na 23	era	11 Marital Status 12. Was Decedent E	ver in U.S. 13. V		nic Origin? (Specify		14. Race - Ameri					
ယ	or iter	핊	Armed Forces?  1 □ Never Married 2 □ Married 12 ◯ Yes 2 □ N	o WWTT	Was Decedent of Hispan f Yes, specify Cuban, Me		n, etc.)	Black, White,					
8	72 hours after death with the Maryland natural, or Itema 23a or 28a-f ehow dical Examinar must be notified at	by	3X Widowed 4 □ Divorced If Yes, Give Year or Dates Ko	orea	1□Yes 2XX No <i>Sp</i>	oecify:		Specify: Wh:	ite				
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121	within ene. than "	mpi	Elementary/Secondary (0-12) College (1-4or 5-12th	-)	DO NOT use retired)		.,,	G 3					
15 D	e filed within al Hygiene. other than vent, the Me		17. Father's Name (First, Middle, Last)	Posta	l Clerk	Mother's Name (Fi		S Army					
Maryland	2 should be and Mental le marked o	To Be	Josef Hutnick			Anna Feci		adir damamo)					
Mar	d 2 sh th and i7 ie m traum		19a. Informant's Name/Relationship (Type, Print) Charmine Starkweather (Niece		ng Address <i>(Street and N</i> <b>Cassell</b> Blv								
Baltimore,	permit. Pages 1 and 2 Department of Health Important: if item 27 i any injury or other tra		20a. Hethod of Disposition	20b. Place of Dispo	sition (Name of natory or other place)	Date	200	. Location - City or To	own, State				
m	Page nent c int: if		Marial 2 ☐ Cremation 3 ☐ Removal from State  4 ☐ Donation 5 ☐ Other (Specify)		National C	cem. 4/22	/05 Ar	lington, V	/irginia				
a	permit. Departn Imports any inju		21. Signature of Funeral Service Licensee		. Name and Address of								
<u> </u>	80 5 5 3				05 Broomes				20676				
	Physician		23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Althird Dumbs  Due to (or as a consequence of):										
	/Medical Examiner		Due to (or as a	A-1	Dicky	,							
		e	if any leading to immediate Due to for as a	consequence of:	inte Aci	El Sale			9				
	uted d ansit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events	bal Val	cute Aci	(1 dind							
oʻ	cate be executed bhysiclan and the burial-transit			consequence of):									
8760,	ate be nysicl he bu	icai	d										
9	death certifical e attending phy ed for use as th	Med	IF FEMALE:					1					
Вох	attend for us	ian/	23b. Was decedent pregnant in the past 12 months?	Fetal death 3	Ectopic pregnancy			23d. Date of deliv Month	ery Day Year				
P.0.	the de	Physician/Medical	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at t 9 ☐ Unknown 9 ☐ Unknown	ine or death 5	Other (specify)								
	The law requires that the di ite has been signed by the bage 2 should be detached		Part II. Other significant conditions contributing to death but	t not resulting in the u	nderlying cause given in	Part I.	23e. Did tobac	co use contribute to t	he cause of death?				
Sp	quires in sign	ed by	Hyperhillin, Hyp	w 11 Pitum	13		1 🗌 Yes	2 □ No 3 ☐ Froi	bably 4 Unknown				
ital Records,	aw rec	ompieted	, "11				24a. Was an	24b. Were auto	opsy findings available				
Ä	The lavate has	E					autopsy performed 1 ☐ Yes 2 ☐	d?   death?	empletion of cause of				
Ta		BeC	25. Was case referred to medical		26.	Place of Death (C)		12103	ga IIV				
$\geq$	d is	10	examiner? 1 Yes 2 No Hospital: 1 Inpatier	t 2 ☐ ER/Outpatien	nt 3□ DOA Other: 4	Nursing Home	5 🗆 Residenc	e 6 □Other (Specia	fy)				
, c	ng Ph (fter th	ë.	27. Manner of Death 1 ☑ Natural 5 ☐ Pending (Month, Day	Year) 28b. Time of Injury	Work?		Describe how	injury occurred					
Sign	Attending in death.	cati	2 Accident investigation	05 6:00			Landa (O)						
Division	after of Direct	Certification;	4 Homicide determined 286. Place of Inju- building, etc	ry - At home, farm, str . (Specify)	eet, factory, office	281.	City or Town, S	t and Number or Run itate)	al Houte Number,				
	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edicai C	29a. Certifier (Check only one)  Certifying Physician: To the best of and manner star	examination and/or in	n occurred at the time, da vestigation, in my opinior	ate and place, and n, death occurred a	due to the caus t the time, date	e(s) and manner as s and place, and due t	stated. to the cause(s)				
	To the within 2 To the complet	Me	29b. Signature and title of certifier		29c. License nun			Date signed (Month,					
)			· /vnn		0006	61947		4/7/4					
	10+1		30 Name and address of person who completed cause of de	Hall I	D Chai	dotte	Hall.	4/7/s	0622				
	Sta Registr		31. Date filed (Month, Day, Year) APR 1 2 2005	s Signature	Sparke								

	•	State of Maryland / Departm State of Maryland / Departm State of Maryland / Departm State of Maryland / Departm Registrer	ate of Death	Reg. No.2 0 0 5	1395						
		Decedent's Name (First, Middle, Last)	2. Date Mor	e of Death nth Day Yeer	3. Time of Death						
Physici: /Medic	_	MAXINE RUTH HUPP		ril 9, 2005	8:23 A						
Examin		4a. Facility Name (If not institution, give street and number)  4b.	City, Town, or Location of Death	4c. County of Dea	th						
		FREDERICK MEMORIAL HOSPITAL	FREDERICK	FREDE							
Funeral		1□M 2√7E GO W Mor	nder 1 Year   If Under 24 Hrs. 8. Date ths Days Hours Min. (Mon	nth, Day, Year) Co	thplace (State or Foreigountry)						
Director		577-30-0461 79 Yrs. Usual Residence of Decedent	05/	18/1925 Pe	<u>nnsylvani</u>						
and and		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limit						
Mary	to	Md. Frederick Frederick	1		tx∏Yes 2□N						
7.288	Director	10e. Street and Number 10	f. Zip Code	10g. Citizen of What Co	ountry?						
73e o	οie	6954 Brighton Circle	21703	USA							
dea	Funerai	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status	ecedent of Hispanic Origin? (Specify Yes	s or No- etc.) 14. Race - Ame							
or ite	F.	1 Never Married 2 Married 1 Yes 2 No If Yes, Give X 1 Y	es 2 No Specify:								
ural',	d by	3 ¼ Widowed 4 □ Divorced Year or Dates:		Specify: W]							
"nat	Completed	(Specify only highest grade completed) (Give kind of	Usual Occupation  If work done during most of working  Tuse retired)	16b. Kind of Business	/Industry						
withing than	m d	Elementary/Secondary (0-12) College (1-4or 5+) Cashi	· ·	arogory (	Store						
Hygie ther int,	e Co	17. Father's Name (First, Middle, Last)		Grocery (	store						
d be ental ked o	To B	Felix M. Bopp	Tanhollo	M. Schrift							
shoul nd Ma marl	F		dress (Street and Number or Rural Route		Zip Code)						
nd 2 alth a 27 is r trat		Donald Robinson 104 Ba	rk Court, Arnold	. Md. 21012							
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: if them 27 is marked other than "natural; or items 23e or 28e-f show any injury or other traumatic event, the Maritial Examinating that it collins a once.		20a. Method of Disposition 20b. Place of Disposition	(Name of Date	20c. Location - City or	Town, State						
Page ent o nt: if ry or	- 3	1X Burial 2 Cremation 3 Hemoval from State	Cemeter 04/12/	OF 11 G	201						
mit. I	1		ne and Address of Facility Charl	OS O Dimen	my,ra.						
E E E E		Dand J. Stoeller, 14. MO1035 Hom	e.Inc.421Manle	St South Fo	a runeta. Ork Polsi						
		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									
Physician			Shoele		Onset and Death						
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Examiner		Sequentially list conditions, b. Septic Shoe	h?								
p #	iner	if any, leading to influediate cause. Enter Underlying Cause (Disease or injury									
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certificate be executed iding physician and tse as the burial-transit	dicai	d									
leath certific attending p	Completed by Physician/Me	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of de	Nivon						
ath itter or u	ian	in the past 12 months?	pic pregnancy er (specify)	Month	Day Year						
the d	ysic	1 Yes 2 No 9 Unknown 9 Unknown	(3500/1)/								
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requires that een signed b nould be deta	D	Coronary artry decease		1  Yes 2  No 3 P	robably 4 Unkno						
> 9 70	lete	Cerebid vasculal accident.	24	a. Was an 24b. Were a	utopsy findings availa						
The lav ate has page 2 :	Ę.			autopsy prior to performed? death?	completion of cause						
Ician: Th certificate ector, pag		25. Was case referred to medical	26. Place of Death (Chec		s 2 No						
	To Be	examiner?	DOA Other: 4 Nursing Home 5		acify)						
g Phys er this eral di		27. Manner of Death 28a. Date of Injury 28b. Time of	28c. Injury at 28d. De	escribe how injury occurred	,,						
Attending F r death. sctor: After by the funera	atio	1 DMatural 5 Pending (Month, Day Year) Injury 2 Accident investigation Month, Day Year) Injury	Work? 1 ☐ Yes 2 ☐ No								
Attender death	Certification:	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, street, f building, etc. (Specify)	actory, office 28f. Loc	cation (Street and Number or Fi by or Town, State)	Rural Route Number,						
- W D	erl	Dulluing, etc. (Specify)	3.0	y or rown, clarer							
s after sin bire	LO.	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occ	urred at the time, date and place, and due	e to the cause(s) and manner a	is stated.						
dospital or thours after uneral Director filled in the bly filled		(Check only 2 Medical Examiner: On the basis of examination and/or investig			e to the cause(s)						
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To the Hospital or a within 24 hours after To the Funeral Director completely filled in Director To the Funeral Director To th		(Check only one) 2 Medical Examiner: On the basis of examination and/or investigence and manner stated.	29c. License number  M DD 0054636	4/3/05	e to the cause(s)  oth, Day, Year)						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day  $\mathbf{P}^{\mathsf{M}}$ **Physician** 3:45 April 10, 2005 Evelyn Marie Jarvis /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Kline Hospice House Mount Airy Frederick If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 ☐ M 2 🖾 F Virginia 84 216-80-1428 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County worle or then "natural", or itams 23s or 28s-f shov the Madical Exer ther next be notified at 1 X Yes 2 ☐ No Director Adamstown Frederick Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 21710 5709 Adamstown Road death Funerai 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status withIn 72 hours efter 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 ☑ No Specify: 21215-0036 Completed by 3 ⊠ Widowed 4 □ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Maryland Be Pages 1 end 2 should be nent of Heelth and Mental Mazie Longerbean ie marked Stanley Virts 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 end 2 s Department of Heelth ar important: if item 27 ie eny injury or other trau once. Walkersville, Maryland 21793 P.O. Box 519 Linda\_Abrecht\_/ Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition April 14, 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 2005 Frederick, Maryland 4 □Donation 5 □ Other (Specify) Resthaven Mem Gardens 22. Name and Address of Facility Stauffer Funeral Home 21. Signature of Funeral Service Licenses 1621 Opossumtown Pike, Frederick, Maryland 21702 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart lailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final proestiv Physician disease or condition resulting in death) /Medical Due to (or as a jonsequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) iner attending physiclen and for use as the burial-transit Physician: The law requires that the death certificate be executed Exami that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b Was decedent pregnant 3 Ectopic pregnancy Day Month in the past 12 months?
1 Yes 2 No
9 Unknown 4☐Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should been: 24b. Were autopsy lindings available prior to completion of cause of death? 24a. Was an autopsy performed? 212 No 1 Yes 2 🗌 No Yes this certificate Place of Death (Check only one) 25. Was case referred to medical examiner? funeral director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE 1 Yes 2 No 1 Inpatient ER/Outpatient 3 DOA Certification; To 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death After t 1 ☑ Natural 2 ☐ Accident or Attending 5 Pending 1 ☐ Yes 2 ☐ No M after death.

I Director: Af
d in by the fur investigation Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 3 Suicide filled in by 4 Homicide within 24 hours a To the Funerel C To the Hospitel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie (Check 29d. Date signed (Month, Day, Year) 29c. License number and title of certifie 29b. Sign Dhah 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) strar's Signature amas State Registrar

			For State Registrar	State of Ma	aryland / [		tment of H <i>ificate of L</i>		Mental Hyg	iene g. No.	2005	13959	
	Physicia	je.	1. Decedent's Name (First, Mid	1/					2. Date of Deat		Year	3. Time of Death	
	/Medic	al	4a. Facility Name (If not instituti	y Kovac	-5		4h Cihi Toum an	Location of Death	April	(0,	2005	15:15 PM	
ı	Examin	er	Howard County		ital		Colur		,		ounty of Death		
	Funeral		5. Social Security Number		e (In yrs. last bir		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,			place (State or Foreign intry)	
L	Director		220 42 9775 Usual Residence of Decedent	IESM ZUF	74	Yrs.			12-27-19	930	Hun	gáry	
	nyland how		10a. State 10b. Coun	ty	10c. City, Town	n or Loca	ation					10d. Inside City Limits	
	8a-fs	ctor	MD Howa	ard	Ell	lico	tt City					1 ☐ Yes 2 ☐XNo	
	with the or 2	Dire	10e. Street and Number 5513 Montgome:	ar Poad			10f. Zip Code 21043				on of What Cou	*	
	death ms 23	nera	11. Marital Status	12. Was Decedent	Ever in U.S.	13. W		spanic Origin? (Sp n, Mexican, Puerto			. Race - Amer	ican Indian,	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Importent: If item 27 is marked other then "neture!, or Items 23a or 28a-f show any Injury or other treumatic event, I've Medical Evertime minist be redifficed at once.	by Funeral Director	1 ☐ Never Married 2 🄀 Ma	If Yes, Give		1	res, specify Cubar ⊒Yes 252tNo	n, Mexican, Puerto Specify:	Hican, etc.)	Si	Black, White pecify:	_	
21215-0036	ture!	ed b	3 Widowed 4 Divorce	Year or Dates:	16a.		nt's Usual Occupa				wn	ite	
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7	led wil	Con		4		Own					eli		
anc	d be fi	o Be	17. Father's Name (First, Middle Antal Kovacs	e, Last)					ie (First, Middle, M z unknowr		umame)		
Maryland	shoul and Me s mark umati	٩	19a. Informant's Name/Relation	nship (Type, Print)	19b	. Mailing	Address (Street a	nd Number or Rui			own, State, Zi	p Code)	
	and 2 ealth a m 27 l		Magdolna Kovad	cs/Wife			Montgomer	-	Ellicott			21043	
Baltimore,	ages 1 nt of H : If ite			3 □Removal from State	cemeter	ry, crema	tion (Name of tory or other place	9)			tion - City or T		
틅	artmer ortent Injury		* 4 □ Donation 5 □ Other and Service 21. Signature of Funeral Service		Metro			4/11, s of Facility Hal			ville. 's Fam	ily FH Inc	
<u>~</u>	permi Depar Impo any Ir		Dhem Colh	is-alth.	mo1044			olumbia I					
				or complications that caused st only one cause on each lin	10.		1 1		or respiratory arre	st,		Approximate Interval Between Onset and Death	
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a			tama	_				NFS	
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	D #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as	a consequence	of):							
	xecute and	Examiner	that initiated events resulting in death) Last	c. Due to (or as	a consequence	of):							
68760,	tificate be executed g physicien and as the burial-transit	edicai E		d									
	ing ph	Medi	IF FEMALE:						nr. se	-			
Вох	The law requires that the death cert ate has been signed by the attendin page 2 should be detached for use	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at	2 Fetal death		ctopic pregnancy Other (specify)			230	d. Date of deliv Month	ery Day Year	
o.	s that the de ned by the a e detached f	hysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown	tille of death	300	ottier (specify)						
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ord	w require been si should b	eted	- Moxi	c energy	o'il	r-cc	<b>y</b>		-	s 2 🗆 ħ	Vo 3 ☐ Prol	oably 4 Durknown	
Records,	The law sate has b page 2 s	Completed	RAW	tes mel	afus				24a. Was ar autopsy perform	<i>r</i>		ppsy findings available impletion of cause of	
Vital	icien: Th certificate rector, pag	Be Co	25. Was case referred to medic	eal /				26. Place of Deat	1 ☐ Yes 2 h (Check only one	No No	1 🗆 Yes	2 <b>X</b> ) No	
		10 E	examiner? 1 X Yes 2 ☐ No	Hospital: 1 1 npatie		tpatient	3 DOA Other		ome 5 Reside		Other (Specif	5/)	
ouc	ding P h. After 1 tunera	tion:	27. Minner of Death  1 Natural 5 Pend	28a. Date of Injur ding (Month, Day stigation		Time of njury	28c. Injury Work' M 1 □ Y	at ? ′es 2 □ No	28d. Describe ho	w injury o	ccurred		
Division of	Attend r death ector: / by the f	Certification:	3 Suicide 6 Coul	d not be 28e. Place of Injuring	ury - At home, fa	rm, stree		35 2	28f. Location (Str	eet and N	lumber or Rura	al Route Number,	
ō	itel or A	Cert		building, et					City or Town				
	To the Hospitel or Attending Phys within 24 hours after death.  To the Funerel Director: After this completely filled in by the funeral di	edicai	29a. Certifier 1 ☑ Certify (Check only 2 ☐ Medical one)	ring Physician: To the best of al Examiner: On the basis of and manner sta	examination and	a, death o d/or inve	occurred at the time stigation, in my opi	e, date and place, inion, death occur	and due to the ca red at the time, da	use(s) an te and pla	d manner as s ace, and due to	tated. the cause(s)	
	To the To the Complet	Me	29b. Signature and title of certif				29c. License	number	29	d. Date s	igned (Month,	Day, Year)	
}				W ND			03	3627	1000	Pri	1 10	2005	
			30. Name and address of prison	n who completed cause of d	eath (Item 23a) (	(Type, Pr	int) (8/1)	ubis	UD	210	44		
•	Sta		31. Date filed (Month Day, Yea	7) 32. Registra	ar's Signature	7	~ 100	100	1-(1)				
	Registr	ar	PI I	L & ZUUJ	was so	A	MAN COMPANY						

				State of Man				•	niene	
			1 - For State Registrar	Otato of Mary		rtificate of			Reg. No.2 0 0 5	13060
			1. Decedent's Name (First, Middle, Last)					2. Date of Dea	ath	3. Time of Death
	Physici /Medic Examin	al	Violet J. Lukasie 4a. Facility Name (If not institution, give si			4b. City, Town, o	r Location of Dea	April	7 2005 4c. County of Dea	12:58 P M
			Montgomery Genera			01ne	y If Under 24 Hr		Montgom	ery
	Funeral Director		5. Social Security Number 6. Sex	M 2√2 F	n yrs. last birthday) Yrs.	Months Days	Hours Mir	n. (Month, Da	y, Year) 9. Bir	thplace (State or Foreign ountry)
	D		Usual Residence of Decedent	85				Sep. 18,	1919   Kho	de Island
	show	'n	10a. State 10b. County		Oc. City, Town or Lo	ocation				10d. Inside City Limits 1 ☐ Yes 2 🔀 No
	28a-f	Director	Maryland Montgomer 10e. Street and Number	у	Silver	Spring 10f. Zip Code			10g. Citizen of What Co	
	h with		3423 S. Leisure Wor	1d Blvd 4	int 2F	20906			USA	,
	ems (ems	Funerai	11. Marital Status	Was Decedent Eve Armed Forces?		Was Decedent of H	lispanic Origin? ( an, Mexican, Pue	Specify Yes or No		
36	rs afte	by Fu	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates:		1 ☐ Yes 2 ☑ No	Specify:		Specify:	
9-0	d within 72 hours after death with the Maryland Jiene. r than "natural", or items 23a or 28a-f show the Medical Examinat must be multied at	ted t	15. Decedent's Educ	ation	16a. Dece	dent's Usual Occup	ation		16b. Kind of Business	White /Industry
215	C 9	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	(Give	kind of work done DO NOT use retired	during most of w d)	orking		,
121	e filed within Hygiene.  other than yent, the Ment, the		12 17. Father's Name (First, Middle, Last)		Hom	emaker	19 Mother's No	ama (First Middle	Own Hom	e
and	6 - 0 S	To Be		1-d					,	
Maryland 21215-0036	should by and Menta s marked sumatic ev	۲	Michael Manaste 19a. Informant's Name/Relationship ( <i>Typ</i>	oe, Print)	19b. Maili	ng Address (Street	and Number or F	Rural Route Numbe	nkiewiczka ar, City or Town, State,	Zip Code)
	es 1 and 2 should bot Health and Ment fitem 27 is marked Lother traumatic e		John Augustyn Luka	Husband siewicz		S. Leisur Sil	ver Spr	Blvd. Ap ing, Maryl	t. 2E and 20906	
Baltimore,	ages 1		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re	1	20b. Place of Dispo cemetery, cre Gate of	osition <i>(Name of</i> matory or other plac Heaven	ce)	Date	20c. Location - City or	Town, State
Ħ	permit. Pages 1 Depertment of H important: If ite any injury ocot		' 4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service License	θ. #	1 2	Cemetery	Apr.		Silver Spr	
Ba	per jmp any		John Collins 1	legge	$\mathbf{F}$	rancis J.	Colling	Funeral	Home, Inc	• MD 20001
			23a. Part1. Inter the disease, or complice shock, or heart failure. List only one	cations that caused the cause be each line.	e death. Do not en	ter the mode of dyir	ng, such as cardia	ac or respiratory ar	rest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	Periphera	1 Vascul	ar Diseas	e			Onset and Death
	/Medical Examiner		resuming in death)	Due to (or as a c	onsequence of):					
b		Jer	Sequentially list conditions, any, leading to immediate cause. Enter Underlying	Directo (or es a o	onsaquence of):					
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760,	ate be executed hysician and he burial-transit	cai E)	in ddain, 220t	Due to (or as a c	onsequence or):					
68	ifficate g phys	ed	d.							
Вох	eath certificat attending phy I for use as thi	an/M	200. Was decedent program	3c. If yes, outcome of g		Dectopic pregnancy	,		23d. Date of de	,
.O. E	The law requires that the death certifica tie has been signed by the attending ph bage 2 should be delached for use as it	Physician/M	in the past 12 months? 1 □ Yes 2 录No 9 □ Unknown	4☐Pregnant at tim 9☐ Unknown		Other (specify)			Month	Day Year
Δ.	that the de led by the a detached f		Part II. Other significant conditions conf	tributing to death but n	ot resulting in the u	nderlying cause giv	en in Part I.	23e. Did to	bacco use contribute to	the cause of death?
Records,	quires an sign uld be	ed by	Bowel Obstructio	n				1 🗆 Y	∕es 2 <mark>v</mark> ∏No 3 □ Pr	obably 4 Unknown
eco	law requas been 2 shoul	Completed						24a. Was		utopsy findings available completion of cause of
E B		Con						perfor	rmed?   death?	2□ No
Vital	Physician: This certificate aldirector, p.	o Be	25. Was case referred to medical examiner?	ospital:		oth Oth	or	eath (Check only o		
of		-	1 ☐ Yes 2 [XNo 27. Manner of Death	28a. Date of Injury	2 ER/Outpatie	f 28c. Injur	y at		dence 6 Other (Spe	cify)
ion	Attending I r death. sctor: After by the funer	atlo	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Y	ear) Injury	M 1 🗆	K? Yes 2 □ No			
Division	ai or Attendii s after death. si Director: A ed in by the fu	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury building, etc. (		reet, factory, office		28f. Location (S City or Tow	Street and Number or Ri vn, State)	ural Route Number,
ш	To the Hospital or J within 24 hours after To the Funeral Dire completely filled in b		29a. Certifier 1X Certifying Physi	ician: To the best of n	ny knowledge, deal	h occurred at the tir	ne. date and place	e, and due to the	cause(s) and manner as	stated
	he Ho in 24 t he Fu pletely	Medical	(Check only 2 Medical Examin	er: On the basis of ex and manner stated	amination and/or in	vestigation, in my o	pinion, death occ	curred at the time, o	date and place, and due	to the cause(s)
	To t To t com	Σ	29b. Signature and title of certiller			29c. Licens	e number		29d. Date signed (Mont	h, Day, Year)
,	5					D 060	15		April 8, 2005	
			30. Name and address of Verson who cor Frederick Beavers				r Dud	#105 B	alered 1.1 - 34	
	Sta	ite	31. Date filed (Month, Day, Year)				r nrive	#105 Ro	ckville,Mar	yland 20850
	Regist	ar	APR 1 1 20	Wallet	Signature	THE REAL PROPERTY.				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Scott N. Labaer State of Maryland / Department of Health and Mental Hygiene

1- State of Maryland / Department of Health and Mental Hygiene
Registrar

Red. No. 05-2679 AKG Reg. No. -2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 2:35 P April 16, 2005 Scott Nathan LaBaer /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner C&D Canal 1/2 mile N of Pennyfield Lock Road Rockville Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1**X** M 2□ F Months 085-48-5568 Director MARCH 29, 1966 NEW YORK Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. Count 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at 1 X Yes 2 □ No Directo MARYLAND | MONTGOMERY BETHESDA 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code ò 238 20817 8713 SEVEN LOCKS ROAD U.S.A. Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. filed within 72 hours after 1 Never Married 2 N Married Maryland 21215-0036 ō 1 ☐ Yes 2 X No Specify: Completed by WHITE 3 ☐ Widowed 4 ☐ Divorced "natural" 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) 5+ PHYSICIAN MEDICAL 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be s 1 and 2 should be fi f Health and Mental H tem 27 is marked ot 2 M. Richard LaBaer Burstein 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health Item 27 I permit. Pages 1 and Department of Health Important: if Item 27 any injury or other troonce. 8713 SEVEN LOCKS ROAD, BETHESDA, MARYLAND 20817 Michelle P. LaBaer/Wife Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 Bemoval from State 4 ☐ Donation 5 ☐ Other (Specify) KING DAVID MEM. GDNS. 04/20/2005 FALLS CHURCH, VIRGINIA 21. Signature of Funeral Service Licens EDWARD SAGEL FUNERAL DIRECTION, INC. Donald. 1091 ROCKVILLE PIKE, ROCKVILLE, MD 20852 ottlemus 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each the. Approximate Interval Between Onset and Death Drowning complicated by diphenhydramine and acetaminophen use Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine sicien and burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): 68760 Physiclan/Medical anding phys use as the Box IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy atter for u in the past 12 months?
1 Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f P.O. 9 Unknown signed to 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. þ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ○ es 2 □ No 24a. Was an autopsy performed page Yes 2 🗆 No Division of Vital Hospital or Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other:  $_{4\,\square\,\text{Nursing Home}}$  5  $\square$  Residence 6  $\cancel{R}$ Other (Specify) at scene Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 9 Yes 2 No 28a. Date of Injury **unk** 28b. Time of **unk** 28c. Injury at (Month, Day Year) Injury Subject took drug and drowned 27. Manner of Death Certification: After 1 Natural 5 Pending death. 1 ☐ Yes 2 X No investigation in river 2 Accident Director: 6 Could not be determined Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1/2 Mile North of efter Found in C&D canal within 24 hours e To the Funeral C Pennyfield Lock Rd Rockville MD 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 2 April 17, 2005 OCME Morrie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MANYSOUTS 111 Penn Street Baltimore, Maryland 21201 KURELL 32 Registrar's Signature 31. Date filed (Month, Day, Year) State APR 2 0 2005 Registra

				State of Ma	aryland	d / Depa	artment of	Health and N	lental Hyg	jiene	000	1 15 0	
		•	For State Registrar		•	Cer	tificate o	f Death	Р	leg. No.	CUU5	135	162
	Dhi.i.		1. Decedent's Name (First, Middle,	Last)			-		2. Date of Dea Month	ith Day	Year	3. Time of	
	Physicia /Medic			Albert	Lina	aberge			Apri1	8	2005	3:20	A M
	Examin	er	4a. Facility Name (If not institution,					, or Location of Death			County of Deat		
			Citizens Nursin		e (In yrs. I	ast birthday)	If Under 1 Yes	ederick ar   If Under 24 Hrs.	8. Date of Birth (Month, Day	_1	rederi	hplace (State o	or Foreign
	Funeral Director		169-26-3889	1⊠M 2□F	71	Yrs.	Months Day	rs Hours Min.	(Month, Day April 2	, Year) $6$ , $1$	Co	untry)	
	pu ,		Usual Residence of Decedent		10a Cib	, Town or Lo	eation					10d. Inside C	
	ehov	7	10a. State 10b. County	. 1								1 ⊠ Yes	,
	28a-f	Director	Maryland Frede	rick		Freder	10f. Zip Code	<u></u>		10g. Citiz	en of What Co	untry?	
	3a or		375 W. Thornhil	1 Place			2	1703		Ur	ited S	tates	
	death	Funeral	11. Marital Status	12. Was Decedent Armed Forces?		S. 13. \	Was Decedent of Yes, specify C	of Hispanic Origin? (Sp uban, Mexican, Puerto	ecify Yes or No-	1	4. Race - Ame Black, White		
Š	or ite	y Fu	1 Never Married 2 Marrie	d 1⊠Yes 2⊡I If Yes, Give			1 ☐ Yes 2 🕱 N		,			hite	
ğ	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f ehow int, the Madical Exacilmer cust be notified at	ed by	3 ☐ Widowed 4 ☒ Divorced  15. Decedent's	Year or Dates:		16a Decec	dent's Usual Occ	cupation		16b. Kir	d of Business/	Industry	
	in 72 n "na Nedic	Completed	(Specify only highest	grade completed)  College (1-4or 5	5+1	(Give	kind of work doi DO NOT use ret	ne during most of work	king			,	
212	d with giene.	mo	Elementary/Secondary (0-12)	4	37)	Off	icer			U.	S. Ar	my	
	m - 9 E	Be (	17. Father's Name (First, Middle, La					18. Mother's Nam			Surname)		
Уa	should be filed within 72 hours after death with the Marylan and Mental Hygiene.  s marked other than "natural", or items 23a or 28a-f ehow umatic event, it a Madical Exactinational be notified at	To	Walter A. Lina			405 14.75		Jessie eet and Number or Rui	A. Lyt1		T C4-4-	Ti- Codel	
Mar	d 2 sh th and 7 is m traum		19a. Informant's Name/Relationshi					Wellsbur					
<u>ق</u>	Heali Heali tem 2		Mara Watson / S  20a. Method of Disposition	Sister	20b. P		sition (Name of natory or other p		Date		cation - City or		
Ē	Pages ent of nt: If i		1 ☐ Burial 2 ☑ Cremation 3 1 ☐ Denation 5 ☐ Other (Spe				c Cremat	ory, Apri	1 9, 2005 F	rede	rick,	Marylan	d
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic e one.		21. Sig ature of Furreral Tervice Li	œnsee /		22	. Name and Ad	dress of Facility St.	auffer F	uner	al Hom	es, P.A	
<u> </u>	8858			100				sumtown Pi			k, Mar		
			23a. Part1. Enter the disease, or c shock, or heart failure. Last or	omplications that caused only one cause on each li	d the death ine.	n. Do not ent	er the mode of o	tying, such as cardiac	or respiratory an	rest,		Approximat Interval Bet Onset and	ween
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	/Medical Examiner		, and a second	Due to (or as Renal H								Week	
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760,	ate be executed hysician and the burial-transit		resulting in death) Last	Due to (or as		,						77 o o 1-	
00	cate b physic the b	dical		d. <u>Urinary</u>	7 Ira	ct ini	ection					Week	
9 X	death certificat e attending phy d for use as th	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome						2	3d. Date of del	ivery	
.O. Box	death a atter d for u	iclar	in the past 12 months? 1 ☐ Yes 2 ☒ No	1 ☐ Live birth 4 ☐ Pregnant a			]Ectopic pregna ] Other <i>(specify,</i>				Month	Day	Year
0	that the de led by the a detached f	hys	9 Unknown	9□ Unknown						_			
	P P P P P P P P P P P P P P P P P P P	by	Part II. Other significant condition Encephalopathy			•	, -	given in Part I.		bacco u: 'es 2 🕽		the cause of cobably 4 🖂	
ord	w requir been si should	Completed					10,	<u>.</u>					
3ec	e law has b je 2 s	mpl	Depression, Con	onary Arter	су рт	sease			24a. Was autop	sy med?	prior to death?	topsy findings completion of c	ause of
a			25. Was case referred to medical					26. Place of Dea		2 🖾 No	1 Yes	2 🔀 No	
5	ıysician: The lav iis certificate has director, page 2	o Be	examiner? 1 Yes 2 No	Hospital:	ent 2	ER/Outpatier	nt 3 DOA	Other: 4 Nursing He			☐Other (Spe	cify)	
Division of Vital Records,	Attending Physician: or death. ector: After this certification of the funeral director.	J: L	27. Manner of Death 1 ⊠Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ury ay Year)	28b. Time or Injury		njury at Nork?	28d. Describe h				
Siol	eath. or: Al	catle	2 Accident investigated in Suicide 6 Could not	ation				☐ Yes 2 ☐ No	00/ 1			10 11	
Ξ	or Attendated after death Director:	Certification:	4 Homicide determin		jury · At ho tc. <i>(Specif</i> )	ome, farm, str v)	eet, factory, offi	Ce	28f. Location (S City or Tow			Irai Houte ivun	nber,
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	To the within 2 To the complet	Ž	29b. Signature and title of ceriffier	P.	00	a. Ma	29c. Lic	ense number		29d. Date	signed (Mont	h, Day, Year)	
	X		• Celler	~ pec		J.M.		54749		Apr	il 8, 2	2005	
	13		30. Name and address of person w			/		D-1 Fred	erick N	(a r 17 1	and 2	1701	
	Sta	ate	Allen Reilly,	2. 2005 32. Figist	rar's Signa	iture	Avenue,	D I FIEU	CLICK, P	штуј	_a.u., 2	. / 01	
	Regist		HPR 1	. 2003		No M							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** April Ronnie Lee Long 2005 3:00P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 800 Motter Ave., Apt. 605 Frederick Frederick 8. Date of Birth Mary Pear) 942 Mary Pand Mary Pand Mary Pand If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6. Sex **Funeral** Months 1**X** M 2□ F 63 218-40-2792 Yrs. Director Usual Residence of Decedent ss 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.
Item 27 is marked other then "naturel", or Items 23a or 28e-f show other traumatic event, the Mcdral Examinar must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Frederick 1 No 2 No Funeral Director Maryland Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 800 Motter Ave., Apt. 605 21701 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 Armed Forces? 1 Armed Process 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White Be Completed by 3 ☐ Widowed 4 Noivorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) heavy equipment operator construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be treet of Health and Menta tent: If item 27 is marked jury or other traumatic ev Edgar Richard Long Hilda Mae Fogle ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Long/ex-wife 3643 Baptist Rd. Taneytown, MD 21787 Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department o Important: If any injury or once \* 4 □ Donation 5 □ Other (Specify) Rocky Hill Cemetery 4/8/2005 nr. Woodsboro, MD 22. Name and Address of Facility Hartzler Funeral Home 21. Signa re of Funeral Service License athanine 404 S. Main St. Woodsboro, MD 21798 23a. Part1. Enter the disease, or complications that paided the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ONGESTIVE Physician NEART VRS disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) Hospitel or Attending Physicien: The law requires that the death certificate be executed the burial-transit Due to (or as a consequence of): Box 68760. use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy j in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) P.0. detached þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Division of Vital Records. OBSTRUCTIVE PULMONARY 1 es 2 No 3 Probably 4 Unknown funeral director, page 2 should Completed COREDROVASCULAR 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate 2 No 1 ☐ Yes 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death | Check on one examiner' Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: Certification: To 1 Yes 2 100 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of After 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No after death Director: / 2 Accident investigation 3 🗌 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide hin 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) within To the comple 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number NJL 02039 allow MY oure 8 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 195 Thomas Johnson Dr. William H. Convey Frederick, MD 21702 31. Date filed (Month, Day, Year) 32. Registrar's Signature APR 06 Elem & Sport 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Month 3. Time of Death Day Year **Physician** 8:25 PM April 8 2005 <u>Mary Angelus Ledden</u> /Medical 4e Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hagerstown Washington Julia Manor Nursing Home If Under 24 Hrs. 8. Date of Birth (Month, Day, Yeer) If Under 1 Year 5. Social Security Number 7. Age (In yrs. lest birthday) Birthplace (Stete or Foreign Country) **Funeral** Deys 1□ M 2√XF Months Director May 20,1922 New Jersey 138-18-3357 Usuel Residence of Decedent 10e. State 10c. City, Town or Location 10d. Inside City Limits 10b. County al Hygiene, other than "natural", or flems 23a or 23a-f show ovent, the Medical Examiner must be notified at 1 Yes 2 □ No Directo Hagerstown Maryland | Washington 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? permit. Peges 1 and 2 should be filed within 72 hours efter deeth with I Depertment of Heelth and Mentel Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or I any Injury or other traumatic event, the Modical Examinat must be n USA 21740 112 W. Howard St. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2000No If Yes, Give Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐XNo Specify: ۾ 3 □XWidowed 4 □ Divorced White Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) Housewife Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) Nellie Duncan Augustus Krohn Charles 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 21713 20135 Scenic View Ct. Boonsboro, Maryland Walter C. Ledden - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4-13-05 Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Cedar Lawn Mem. Park 21. Signature of Figure al Servica Logist Osborne AdFresné Paily Home, P.A. ayu 425 S. Conococheague St. Williamsport, MD 21795 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or reart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 1 Yes 2 No 1 ☐ Yes 2 XNo : After this certifice e funerel director, p 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Sursing Home 5 Residence 6 Other (Specify) 1□ Yes 2 No edicai Certification: To 28b. Time of 28c. Injury at Work? 28a. Date of Injury (Month, Dey Year) 28d. Describe how injury occurred 27. Manner of Deeth Naturel 2 Accident 5 Pending s efter dee... al Director: After 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide within 24 hours a To the Funeral C completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end placa, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29a. Certifier (Check only one) 29b. Signature and title of pertified 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) I OPAL CT. HAGERSTOWN MD 45HA MD

State Registrar

DHMH 16 Rev 6/95

			Flease I	State of Maryland / D			•	•	
			1 - State Registrar		Certificate of	Death	Re	g. No 2005	13965
Е	Physicia	an	1. Decedent's Name (First, Middle, Last)		•		2. Date of Death Month	Day Year	3. Time of Death
}	/Medic		Joseph John McNall  4a. Facility Name (If not institution, give s	<del></del>	4b. City. Town.	or Location of Death	April 7	4c. County of Dea	9:25pm M
	Examin	er	Shady Grove Advent		Rockvil			Montgome	
	Funeral		Social Security Number     6. Sex	7. Age (In yrs. last bin		r If Under 24 Hrs.	8. Date of Birth (Month, Day,		thplace (State or Foreign ountry)
	Director		197-10-7999 Usual Residence of Decedent	<sup>IM 2□ F</sup> 84	Yrs. Months Days	S Hours Will.	May 27,	1920 Pen	nsylvania
	aryland show	7	10a. State 10b. County	10c. City, Town	n or Location				10d. Inside City Limits 1 ☐ Yes 2 ☒ No
	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other then "natural", or Items 23e or 28e-f show eumatic event, the Medical Extra. In finial be notified at	Directo	Maryland Montgomer  10e. Street and Number	y Gaithe	ersburg 10f. Zip Code		10	g. Citizen of What C	
	130 o	Q JE	9701 Fields Road #	1808	20878		U	nited Sta	tes
	deat fring	Funeral		12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of If Yes, specify Cu	Hispanic Origin? (Sp		14. Race - Am Black, Whi	erican Indian,
36	or Ite	by Fu	1 Never Married 2 Married	1 MYes 2 □ No If Yes, Give	1 ☐ Yes 2 🗓 No		, , , , , , , , , , , , , , , , , , , ,	Specify:	
Ş	hours tural	d be	3 ☐ Widowed 4 ☑ Divorced  15. Decedent's Educ	Year or Dates: WWII	Decedent's Usual Occi	ination	1	6b. Kind of Business	hite
Maryland 21215-0036	in 72 "na" r	Completed	(Specify only highest grade		Decedent's Usual Occu (Give kind of work done life. DO NOT use retir	e during most of worl ed)	king '	OD. Raid Of Busiless	unidustry
212	yiene.	шо	Elementary/Secondary (0-12)	College (1-4or 5+) 4 F	Budget Anal	yst	S	ecretary	of Defense
힏	a filed al Hyg otha vent,	Be C	17. Father's Name (First, Middle, Last)			18. Mother's Nam	e (First, Middle, M	laiden Surname)	
<u>la</u>	Menta Menta arked	ToE	Joseph John McNall			Mary Flo	eming		
lar a	2 sho		19a. Informant's Name/Relationship (Typ		. Mailing Address (Stree				
<u>ح</u> ش	1 and 1ealth sm 27 ther tr		Patricia McNally E		422 East f Disposition (Name of			more, MD  Oc. Location - City or	
Baltimore,	Pages nent of H		1 ☐ Burial 2 🖾 Cremation 3 ☐ Re	emoval from State cemeter	ry, crematory or other pl	ace)			
탶	artmer ortent injury		' 4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Fugeral Service License		politan Cre	matory 4/8 ress of Facility De	3/05 A eVol Fune		, Virginia
Ba	permit. Pages 1 and 2 should be Department of Health and Menta Importent: If item 27 is marked any injury or other treumatic evens.		Flat X	1211	10 East D Gaithersb	eer Park I	rive		
			23a. Part1. Enter the disease, or complice	cations that caused the death. Do r				st,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Myocardial Ir					Onset and Death
1	/Medical		resulting in death)	Due to (or as a consequence					
	Examiner		Sequentially list conditions, b	Sepsis	0				
	ed sit	ulne	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Disease or injury	Due to (or as a consequence					
	be executed sician and burial-transit	Examiner	that initiated events cresulting in death) Last	Renal Failure  Due to (or as a consequence					
760	le be executed ysician and e burial-transit	calE	d						
89	tificati ig phy as the							1	
Box	leath certifica attending pl	an/N	23b. was decedent pregnant	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death	3 ☐Ectopic pregnan	cy		23d. Date of de Month	livery Day Year
о. П	The law requires that the death certifical ate has baen signed by the attending phyage 2 should be detached for use as the	Physiclan/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of death 9□ Unknown	5 Other (specify)			WORL	Day
۵.	res that the de signed by the a be detached t	Phy	Part II. Other significant conditions con	tributing to death but not resulting in	n the underlying cause o	even in Part I.	23e. Did toba	acco use contribute t	o the cause of death?
Division of Vital Records,	signe Id be	d by	•		, ,		1 🗆 Yes	s 2 <b>½</b> No 3 □ P	robably 4 🗆 Unknown
S	w require baen sig should b	lete					24a. Was an		utopsy findings available
Re	The law cate has page 2:	Completed					autopsy perform	ed? death?	completion of cause of
ta		Be C	25. Was case referred to medical			26. Place of Dea	th (Check only one		20140
>	Physicien: r this certifica ral director,	To E	examiner? 1 ☐ Yes 2 📉 No	lospital: 1 X Inpatient 2 ☐ ER/Ou	utpatient 3 DOA	ther: 4 🗌 Nursing H	ome 5 🗆 Resider	nce 6 Other (Spe	ecify)
0	ng Pt fter th		27. Manner of Death 1    Natural 5 □ Pending			ork?	28d. Describe how	w injury occurred	
Sio	Attending or death.  ector: After by the fune	catl	2 Accident investigation 3 Suicide 6 Could not be	DD Diversitation Alberta (		]Yes 2∏No	206 Leasting (Str	not and Alumbus as F	ham I Donato Marahas
$\leq$	I or Attending after death. Director: After I in by the funer	Certification;	4 Homicide determined	28e. Place of Injury - At home, fa building, etc. (Specify)	arm, street, factory, office	9	City or Town,	eet and Number or R State)	urai Houte Number,
_	To the Hospitel or Attending Physicien: within 24 hours after death.  To the Funerel Director: After this certific completely filled in by the funeral director.		29a. Certifier 1   Check only 2   Medical Examir	sician: To the best of my knowledge ner: On the basis of examination an	e, death occurred at the	time, date and place,	and due to the cau	use(s) and manner a	s stated.
	o the ! ithin 24 o the F	Medical	one) 29b. Signature and title of certifier	and manner stated.		nse number		d. Date signed (Mon	
	F 3 F 8		) olla			02648900		ril 8, 20	
	IŚ		30. Name and address of person who co	mpleted cause of death (Item 23a)		520-TO 700	Ар	0, 20	
			Thomas Odar, M.D.,	, 15225 Shady Gr	ove Road #2	01 Rockvi	lle, MD 2	.0850	
	Sta Registi		31. Date filed (Month, Day, Year)	37 Registrar's Signature	porte				

amend Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State of Mary
1 - Registre-AMEND#5perFH4/11/05, EMW, McCo Certificate of Death Reg. No., 1. Decedent's Name (First, Middle, Last) 2 Date of Death Day Month Year **Physician** Barbara D Moore 04 6:40 PM 06 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard Howard HOSPITAL Columbia GENERAL County If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 7. Age (In yrs. last birthday) 6. Sex **Funeral**  Birthplace (State or Foreign Country) 1 □ M 2 1 F Director 1927Dist Of Col Usual Residence of Decedent death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiane. Important: If item 27 is marked othar than "natural; or items 23a or 28a-f show any injury or other traumatic event, the Midical Examinational by notified at once. 10a State 10c. City. Town or Location Howard 10d. Inside City Limits XXYes 2 No Director Md Prince George Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20723 U.S.A. Ave, 9941 Naylor Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ Nox Specify: If Yes, Give Year or Dates: Specify: Black XXWidowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Personnel Admin Asst University Of Md Yrs 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Anna Carter 2 Benjamin A. Adams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Denise Moore (Daughter) 9941 Naylor Ave, Laurel, Md #20723 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State <sup>1</sup> 4 □ Donation 5 □ Other (Specify) Md Veterans Cem. 5/12/05 Cheltenham, Md Signature of Funeral Service Licenses 22. Name and Address of Facility Snowden Funeral Home P.A. 20850 246 N. Washington St. Rockville 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pulmonary Edema Priysician 48 h /Medical Due to (or as a consequence of) Examiner Congestive Heart Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (ar as a consequence of) Physician/Medical Examiner Hospital or Attanding Physician: The law requires that the death certificate be executed the burial-transit 5 days Myocarcha resulting in death) Last Due to (or as a consequence of) Box 68760. IF FEMALE esn 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 Live birth 2 ☐ Fetal death in the past 12 months?
1 Yes 2 No
9 Unknown Month Year 4☐Pregnant at time of death 5 Other (specify) P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records. RENAL FAILURE 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24a. Was an autopsy performed? 1 ☐ Yes 2 € No 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No director. Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: | Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA this 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident Injury 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) þ 4 - Homicide filled in within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To tha 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) Mari D 005 4450 4/6/05 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10724 Little Patuxent Parkway, Columbia, MD, 21044 Maria JISOn 31. Date filed (Month, Day, Year) 32 Registrar's Signature State APR 11 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Year 1105 055120 /Medical Hoch 3002 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Point hestertour Year If Under 24 Hrs eron If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign PA **Funeral** Days Months Hours Min. 1 M 2 ☐ F 88 50549071 Usual Residence of Decedent Director 19, Nov. with the Maryland 10a. State 10c. City, Town or Location show 10b. County 10d. Inside City Limits item 27 la markad other than "natural", or Itams 23a or 28a-f show other traumatic event, the Nedical Evanting must be notified at Director MD 1 X Yes 2 ☐ No Kent Chestertown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 487 HEron Point 21620 USA death ( by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 Ia markad other than "natural", or Itan any injury or other traumatic event, Ita Medical Experiment once. Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 □XYes 2 □ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) 5+ Elementary/Secondary (0-12) Naval Officer Military 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Charles H. Morrison, Sr. Gertrude Macdonald 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles H. Morrison III/Son 1454 Wilderness Ridge Trail, Crownsville, MD 21032 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐XCremation 3 ☐ Removal from State Chesapeake Cremation April6,2005 Stevensville, MD \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Fellows, Helfenbein & Newnam Funeral Home, P.A. 130 Speer Road, CHestertown, MD 21620 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on pach line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** nero Cen disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions. ner Due to (or as a consequence ory Tany, Leading to immediate cause. Enter Underlying Cause (Disease or injury the attending physician and hed for use as the burial-transit death certificate be executed Exam that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. 1 ☐Yes 2☐No be detached 9 Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ plnous 1 Yes 2☐NO 3☐ Probably 4 ☐Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No this certificate has page 2 autopsy 21 No 20 No 1 ☐ Yes Physician: 25. Was case referred to medical examiner? Be 26. Place of Death. Check only one) Hospital: Other: 1 Yes 2 No 10 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending After 1 TNatural 5 Pendina within 24 hours after death. To the Funeral Diractor: A investigation 1 🗌 Yes 2 No 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) the 29b. Signature and itle of certific 101 29d. Date signed (Month, Day, Year) 10060301 30. Name and address of perion who completed cause of death (Item 23a) (Type, Print). 31. Date filed (Month, Day, Year) . Registrar's Signature State APR 0 7 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day 6:25 P M Francis R. Mitchell April 10 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Vantage House Columbia Howard If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months **1** M 2 □ F Director 718 16 9033 92 15, 1912 North Carolina Usual Residence of Decedent 10a. State 10c. City, Town or Location worde ! 10d. Inside City Limits the Medical Examiner must be notified at 1 ☐ Yes 21 No Director MD Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 238 5400 Vantage Point Road #419 21044 United States death or Itams 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. fited within 72 hours after 1 □ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 3⁄☐ No Specify: þ Specify: 3√2 Widowed 4 □ Divorced "natural" White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Owner Distributor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 12 should be fi h and Mental H 7 ie marked otl Charles Ray Mitchell Mattie Josie Marsh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 ment of Health a ant: If item 27 is A. Kent Mitchell/Son 10 Gray Heron Retreat Avannah, GA 31411 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 

Burial 2 □ Cremation 3 □ Removal from State injury or permit. Page Department of Important: If any injury or once. St. Johns Cemetery 4-13-2005 \* 4 ☐ Donation 5 ☐ Other (Specify) Ellicott City, MD 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 21. Signature of Funeral Service Licenses M01044 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Renal Cell Cancer /Medical Due to (or as a consequence of) Examiner Bladder Cancer Sequentially list conditions, if any, leading to immediate the first injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physician and the burial-transit death certificate be executed Prostate Cancer Due to (or as a consequence of): Box 68760 Physician/Medical ď. use as I attending IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy ş in the past 12 months? Day 4□Pregnant at time of death 5 ☐ Other (specify) P.O. the 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Records. cate has been sig , page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed certificate 2X No Division of Vital 1 Yes 2 No 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 45 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Injury 1 XNatural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation М 2 Accident or Attend after death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D53987 April 10, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kenneth Geh, MD 300 Armory Pl Suite 39 Baltimore, MD 21201 31. Date filed (Month, Par Kear) 2 32. Registrar's Signature State Registrar

			1 - For State Registrar	State of M	laryland / Dep <i>Ce</i>	artment of F			/11115	13969
			Decedent's Name (First, Middle	e, Last)		Timodio or	Dodin,	2. Date of Death	g. No:	3. Time of Death
	Physici		Howard T	uther Mot	- 0.76			Month	Day Year	M
	/Medio Examir		4a. Facility Name (If not institution			4b. City, Town, o	r Location of Deat	April	3, 2005 4c. County of Death	9:19p <sup>™</sup>
	-xaiiiii			k Memorial			derick			
	Funeral		5. Social Security Number	6. Sex 7. A	ge (In yrs. last birthday	If Under 1 Year	If Under 24 Hrs	8. Date of Birth	Frede	
В	Director		212-18-2044	XXM 2□F	89 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, )	8,1915 Mary	place (State or Foreign Intry)
	D.		Usual Residence of Decedent					осрешьсь	0, 10 10   LIGIT Y	Tand
	how	_	10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
	e Ma ka-1 e	Director	Maryland Carrol	L1	Union Br	idge				1 □ Yes 2 No
	ith th	Slre.	10e. Street and Number			10f. Zip Code		109	g. Citizen of What Cou	intry?
	23a	- a	13509 Good Inte	ent Road		21791		U	nited Stat	es
	r deg	ıne	11. Marital Status	12. Was Decedent Armed Forces	?	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (S	pecify Yes or No-	14. Race - Amer Black, White	can Indian.
36	s afte	γFι	1 Never Married 2 Marr	If Yes, Give	No	1 ☐ Yes ZiNo	Specify:	, , , , , , ,		ite
Ö	within 72 hours after death with the Maryland ene. than "neturel", or Items 23a or 28a-f ehow the Medical Examirar must be notified at	Completed by Funeral	XX Widowed 4 □ Divorced	Year or Dates:						
5	n 72 "nel	lete	15. Decedent (Specify only highes	it grade completed)	(Give	dent's Usual Occup: kind of work done of DO NOT use retired	during most of wor	rking	6b. Kind of Business/Ir	ndustry
12	withi ene. then	mc	Elementary/Secondary (0-12)	College (1-4or	5+)		"			
р О	filled Hygi ther ant,	ပို	17. Father's Name (First, Middle,	Last)	Farm	er	18 Mother's Nar	ne (First, Middle, Ma	griculture	
an	d be ental ced c	o Be							adon damane)	
2	shoul nd M mari	L 2	Elmer Joseph Mc 19a. Informant's Name/Relationsh		19b. Maili	na Address (Street :	Grace B		City or Town, State, Zi	n Codol
Š	nd 2		Joan Mercer/ Da	wohtor			asser toger			
ē,	Hea Hea tem othe		20a. Method of Disposition		20b. Place of Dispe	sition (Name of	-		Maryland 2 Dc. Location - City or T	
J10	ages ant of t: If i		1 XXBurial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp	3 Removal from State		matory or other plac				
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "neturel", or Items 23a or 28a-1 ehow any injury or other traumatic event, the Medical Examinatment be notified at once.	. 17	21. Signature of Funeral Service I		GLACE EII M	Name and Address	cri Cereter	y April 0,2	005 Thurmon Funeral Ho	t, Maryland
Ba	Dep any		2 20 MO	).						
Ĺ			23a. Part 1. Enter the disease, or	complications that cause	d the death. Do not en	J4 Last M.	<u>ain Stre</u>	et/ Inurmo	ont,Maryla	nd 21/88 Approximate
П	<b>D</b>		shock, or heart failure. List	only one cause on each I	ine.		9)	or respiratory arros		Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a	Sepsis					
П	Examiner	İ		Due to (or as	a consequence of):					
		e.	Sequentially list conditions, if any, leading to immediate	b Due to (or as	a consequence of):					
	uted d ansit	Examiner	Cause (Disease or injury that initiated events							
Ć,	be executed sician and burial-transit	Exa	resulting in death) Last	c. Due to (or as	a consequence of):					
8760,	ate be executed thysician and the burial-transit	dlcal		d						
9	tificate ng physi as the l	led							, i	
Вох	eath certific attending p I for use as	Ş	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		Testania avana			23d. Date of delive	эгу
m,	deat	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐ Pregnant a		Ectopic pregnancy Other (specify)			Month	Day Year
<u>о</u> .	by the	hys	9 🗌 Unknown	9□ Unknown						
	res that the de signed by the a be detached f	by F	Part II. Other significant conditio	ns contributing to death b	out not resulting in the u	nderlying cause give	en in Part I.	23e. Did tobac	cco use contribute to the	ne cause of death?
ğ	w require been sig should b	ed	Scizure					1 ☐ Yes	2 No 3 Prob	ably 4 Unknown
Records,	S 53	Completed						24a. Was an	24b. Were auto	psy findings available impletion of cause of
_	The l	E O						autopsy performe 1 ☐ Yes 2*	d'/ death?	mpletion of cause of 2□ No
Vital	sicien: Th certificate rector, pag	Be	25. Was case referred to medical examiner?				26. Place of Dea	th (Check only one)	12163	20110
<u>&gt;</u>	hyeic his ce I dire	2	1 Yes 2 No	Hospital: 1 Inpatio	ent 2 ER/Outpatier	it 3 DOA Othe	r: 4 🗆 Nursing H	ome 5 🗆 Residenc	ce 6 Other (Specif	y)
0	ding Ph h. After th funeral		27. Manner of Death  1 Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	y Year) 28b. Time o	28c. Injury Work		28d. Describe how		
Sio	tendii feath. tor: A the fu	cati	2 Accident investig	ation			′es 2□No			
Division of	or Att	Certification;	3 Suicide 6 Could n 4 Homicide determin	ned 28e. Place of Inj building, et	ury - At home, farm, str c. (Specify)	eet, factory, office		28f. Location (Stree City or Town, S	et and Number or Rura State)	l Route Number,
	spitel o									
	To the Hospitel or Attending Phyeicien: within 24 hours after death. To the Funerel Director: After this certifica completely filled in by the funeral director.	edical	(Check only 2 Medical E	Physician: To the best examiner: On the basis o	f examination and/or in	occurred at the time vestigation, in my on	e, date and place, inion, death occur	and due to the caus	se(s) and manner as s	ated.
	To the How within 24 h To the Fur completely	Med	one) 29b. Signature and title of certifier	and manner st	ated.					
	To To		255. Signature and title of certifier	** 0		29c. License			Date signed (Month,	
			SYW	M M D.			055793		7/7/0	5
			30. Name and address of person v	ho completed cause of c	TIV	AA 1	Unental			
	C		31. Date filed (Month, Progress)	TUNON IT .V.	ar's Signature	Monorial	Hospital			
	Star Registra		APR	2 2005 32. Hadrstr	on At a	Secret .				
		· v			60	P. W.				

			1 - For State Registrar	State of	Maryland		artment rtificate			and Me	-	giene Reg. No.	005	13970
	Physici	an	1. Decedent's Name (First, Midd.							1	2. Date of De _Month		Year	3. Time of Death
1	/Media	al	Marion	Agnes	McKimm	ie					April		005 Year	9:10 P M
4	Examir	er	4a. Facility Name (If not institution  Southern Mary			ton	4b. City, 1			of Death			County of Death	
	Funeral		5. Social Security Number		. Age (in yrs. la		If Under		If Under		3. Date of Bir	th	9. Birth	eorge's place (State or Foreign
	Director		577-16-0920	1□M 27 F	86	Yrs.	Months	Days	Hours	Min. I	(Month, Da	v. Year)	19 Mass	achusetts
	pu k		Usual Residence of Decedent  10a. State 10b. County		10c City	Town or Lo	neation							
	Aaryle f sho	ō		e George's		coke								10d. Inside City Limits 1 ☐ Yes 2 No
	the 28a-	rect	10e. Street and Number	c deorge 3		COKE	10f. Zip (	Code				10g. Citize	en of What Cou	
	h with	i Di	15913 Dusty	Lane			,	0607				_	S.A.	, .
	ems 2	ner	11. Marital Status	12. Was Deced	ent Ever in U.S	. 13.	Was Decede	ent of His	spanic Ori	gin? (Spec	ify Yes or No		4. Race - Amer Black, White	
36	or It	by Funeral Director	1 ☐ Never Married 2 ☐ Mar 3 🛣 Widowed 4 ☐ Divorced	ned 1 ☐ Yes 2	M No		1 □ Yes 2		Specify:	, , , ,			Specify: Wh	-
21215-0036	within 72 hours aftar death with the Maryland ene. then "naturel", or Items 23a or 28a-f show the Mudical Examinar must be notitied at	ed b		Year or Dat	es:		dent's Usual		tion				d of Business/li	
15	n "na	piet	(Specify only higher Elementary/Secondary (0-12)	st grade completed)	los Eu)	(Give	kind of work DO NOT use	k done d	urina mos	t of working	7	TOD. KING	d of business/fi	ndustry
212	glene grene er the	Completed	12	College (1-4	101 5+)	Hor	nemake	r				Ov	wn Home	
bu	ba fife tal Hy d oth	Be	17. Father's Name (First, Middle,								First, Middle,			
<u>\</u>	d Man narke	10	Thomas Edwar				- 121				ecelia			
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mantal Hyglene. Important: If item 27 is marked other then "naturel", or Items 23a or 28a-f show any injury or other treumatic event, the Mudical Examinet must be notified at ance.		19a. Informant's Name/Relations Patricia Maddy								nesvil		Town, State, Zi VA 201	
	Heal Heal tem 2 other		20a. Method of Disposition		20b. Pla		osition (Name matory or oth			, ua i	- decide		ation - City or T	
OE.	Pages ent of nt: If i		1 X Burial 2 ☐ Cremation  4 ☐ Donation 5 ☐ Other (5	3 ☐Removal from St Specify)						04_11	1-2005		cataway	
Baltimore,	mit. F partm sortal r Injui		21. Signature of Funeral Service				Name and	Address	s of Facilit	v	1-2003	ГІЗ	cataway	טויו פ
ä	Depar Impo any tr		John Hoya	e			Huntt P.U.	Box	156.	Home Wald	orf, M	D 20	0604	
			23a. Part1. Enter the disease, o shock, or heart failure. List	r complications that cau only one cause on eac	used the death. ch line.	Do not ent								Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	- Pul	monary	Insuls	Lenus	1						Onset and Death
	/Medical Examiner		resulting in death)	10	r as a conserue	(A.):	/							
		ğ	Sequentially list conditions,		ucmetu as a conseque									
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	<b>S</b>	·									
o,	axec an an rial-tr	Exa	resulting in death) Last	Due to (or	as a conseque	ence of):								
8760,	The law requires that the death certificate be axecuted ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dicai		d.										
9	death certific attending pl	40 ±	IF FEMALE:	220 Maria cutos	om a of program									
Box	attend for us	Physician/M	23b. Was decedent pregnant in the past 12 months?		h 2 ∏ Fetal d nt at time of dea	leath 3	Ectopic pre Other (spe					23	3d. Date of deliv Month	ery Day Year
o.	that the de ad by the detached	ysic	1 □ Yes 2 ☒ No 9 □ Unknown	9□ Unknow		. J	1 Other (spe	city)						
d .	res that ignad b be deta		Part II. Other significant conditi	ons contributing to dea	th but not result	ting in the u	nderlying car	use give	n in Part I.		23e. Did to	obacco use	e contribute to t	he cause of death?
Records,	ed sign	Completed by	preast conce	n, Corone	us an	en c	lesea	se,			1 🗆 \	/es 2□	No 3 Pro	bably 4 DUnknown
900	e law requ has been je 2 shouli	piet	dehydrati	en		/					24a. Was		24b. Were auto	ppsy findings available
B		Com			/				_			med?	death?	omptetion of cause of 2□ No
Vital	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medica examiner?							of Death (	Check only o	пе)		
of	Physic this c	To.	1 ☐ Yes 2 No  27. Manner of Death	Hospital: 1XInp		R/Outpatier			4 🗆 Nu				Other (Specia	(y)
O		tion	1 Natural 5 ☐ Pendir		Day Year)	Injury	M 20	lc. Injury Work'	at ? es 2 □ t		d. Describe h	tow injury o	occurred	
Division	I or Attendii after death. Director: A I in by the fu	ifica	3 ☐ Suicide 6 ☐ Could	not be 28e. Place o	f Injury - At hom	ne, farm, str					f. Location (S	Street and i	Number or Run	al Route Number,
Ö	al or A s after al Direct	Certification;	4  Homicide determ	building	, etc. (Specily)						City or Tou	vn, State)		
	To the Hospital or Attending within 24 hours after death. To the Funerel Director: Afte completely filled in by the fune		29a. Certifier 1 Certifyii	ng Physician: To the b Examiner: On the bas	est of my knowl	edge, deatl	h occurred a	t the time	e, date and	d place, an	d due to the	cause(s) ar	nd manner as s	stated.
	the H hin 24 the F nplete	Medical	U18)	and manne	r stated.									
<b>\</b>	To To	-	29b. Signature and title of certifie	or 20 - 42				License		-1	;	29d. Date :	signed (Month,	Day, Year)
7			MICHIE	J.W.D		20-1 7		00	580	フー		4/8	5/0>	
S	1910		30. Name and address of person  AMIT AMM PASTO	CL 8926 14	of death (Item 2	Ro Ci	erint)	1 0	1 1417	2.4/ A	11 2	72/		
1	Sta	te	31. Date filed (Month Pey Year)	2 2005 32. Re	of death (Item 2	10,50	M	1	1-10V(	W /	1 4	1135		
	Registr		Ark 1	£ 2000	were.	N. A	perk	9						

			1 - For State Registrar	State of I	Maryland	d / Depa		t of H	ealth a		fental Hy	-	0.5	13971
п	Physici	an	1. Decedent's Name (First, Midd								2. Date of Dea Month	ath Day	Year	3. Time of Death
	/Medic		AGNES	PE	ARL		MYE	RLY			MARCH		005	8:25A M
1	Examin		4a. Facility Name (If not institution	•	·				Location o	of Death		4c. Coun	ty of Death	
			FREDERICK					DER:					DERIC	CK
	Funeral Director		5. Social Security Number 216-82-9136  Usual Residence of Decedent	6. Sex 7. 1 ☐ M 2 ☐ ★F	Age (In yrs. I	ast birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	Min.	8. Date of Birth Jan . II,	rg18	9. Birth Cou Ma r	place (State or Foreign intry) Y land
	land ow		10a. State 10b. County	у	10c. City	, Town or Lo	cation						1	10d. Inside City Limits
	Many -1 sh	현	Maryland Carr	oll			Taney	/towr	1					1 ☐ Yes 2 No
	r 28a	Funeral Directo	10e. Street and Number				10f. Zip					10g. Citizen o	f What Cou	intry?
	133 o	Ξ̈́	16942 Bull Fr	og Rd.				217	787			U.	s.A.	
	deat	ner	11. Marital Status	12. Was Decede Armed Force		S. 13. V	Was Deced	ent of His	spanic Ori	gin? (Sp	ecify Yes or No- Rican, etc.)	14. Ra		ican Indian,
9	after or its		1 Never Married 2 Mar				rres,spec 1 ☐ Yes 2		Specify:	, Pueno	Hican, etc.)		ack, White	, etc.
8	72 hours after death with the Maryland natural', or itams 23s or 28s-1 show disal Exaciliat sust be notified at	db	3 Midowed 4 Divorced	Year or Date	s:		10 105 2		<i>эр</i> еспу:			Spec	w W	hite
5	72 h 'natu	Completed by		nt's Education est grade completed)		16a. Deced (Give	dent's Usua kind of wor DO NOT us	l Occupa k done di	tion uring most	of work	ing	16b. Kind of	Business/Ir	ndustry
7	vithin ne. han	E E	Elementary/Segondary (0-12)	College (1-4d	or 5+)		oo not us nomema					OWB	home	
2	iled v tygie ther t	ပိ	17. Father's Name (First, Middle,	(act)	-	<u> </u>			10 Motho	rla Blam.	(Ciant Adiatal)			
and	I be f ntal h ad of	Be	Melvin Luthe								e (First, Middle, de Klin		lme)	
2	hould d Me mark matic	P L	19a. Informant's Name/Relations			10h Mailin	a Addraga	(Stroot a					- 01-1- 7	0.43
Ma	d2s than than 7 Is I		Janet Levering			16942					al Route Numbe Taneyt			
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importants If item 27 is marked other than "natural", or Itams 23a or 28a-f show any injury or other traumatic event, the Madical Examinational Legisland at Once.		20a. Method of Disposition	, daugneer	20b. Pla				-		Date	20c. Location		
nor	ages int of t: If it		1 X Burial 2 ☐ Cremation			ace of Disponentery, cren								
를	artme artme ortani injury		*4 ☐ Donation 5 ☐ Other (S		ROC	ky Hil	I Len	eter	y 4	/2/2	005	nr. Woo	odsbo	ro, MD
Ba	permi Depa Impo any ir		atharine	O. Xlan	Rler	1 4	04 S.	Mai	n St	'Har •	tzler F Woodsbo	uneral ro, MD	Home 2179	8
	Physician /Medical Examiner	_	23a. Part1. Enter the disease, o shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions,	a. Due to (or b.	as a consequence as a c	NIA ence of):	er the mode	e of dying	, such as	cardiac	or respiratory arr	est,		Approximate Interval Between Onset and Death
8760,	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dical Examiner	if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last	6	as a consequ									
P.O. Box 6	at the death certific by the attending p tached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcon 1 □ Live birth 4 □ Pregnant 9 □ Unknown	2 Fetal of dea	death 3	Ectopic pre						ate of deliver	ery Day Year
	w requires that been slgned should be det	by	Part II. Other significant conditi				derlying ca		n in Part I.					he cause of death?
Vital Records,	ysician: The law r is certificate has be director, page 2 sh	Completed									24a. Was a autops perform	sy	Were autoprior to codeath?	psy findings available mpletion of cause of
/ita	iician: Th certificate rector, pag	Be	25. Was case referred to medica examiner?							of Death	(Check only on	(8)		
	Physic this ca	ို	1 ☐ Yes 2 ☐ No	Hospital:		R/Outpatient		-	4 🔲 Nui		ne 5 ☐ Reside			y)
Division of	To the Hospital or Attanding Physician: within 24 hours after death. To the Funaral Director: After this certification properties to the funaral director, to the funaral director, to the funaral director, to the funaral director, to the funaral director, to the funaral director, to the funaral director, to the funaral director, to the funaral director, to the funaral director, to the funaral director, to the funaral director, to the funaral director, to the funaral director, to the funaral director, the funaral director, the funaral director of the funaral director.	Certification;	27. Manner of Death  1 Natural 5 Pendir  2 Accident investi  3 Suicide 6 Could	gation not be		28b. Time of Injury	М		at es 2⊡N	lo	28d. Describe ho			
DİX	To the Hospital or Attanding I within 24 hours after death. To the Funeral Director: After completely filled in by the funer		4 Homicide determ	building,	etc. (Specify)						City or Towr	n, State)		al Route Number,
	the Hosp in 24 hol iha Funa pletely fi	edicai	29a. Certifier (Check only one)  Certifyir 2 Medicel	ng Physician: To the bes Exeminer: On the basis and manner	or examination	rledge, death on and/or inv	occurred a estigation,	t the time in my opi	, date and nion, deat	l place, a h occurre	and due to the ca ed at the time, d	ause(s) and m ate and place,	anner as si and due to	tated. the cause(s)
	To t To t	Σ	29b. Signature and title of contifie	1/1	MO			License				9d. Date signe		* '
1	172		/ / falu	yamı ,				0-	573	196		April	1,2	2005
	MIL		30. Name and address of person Lalit Verma	who completed cause of 400 W.			rint)				D 21701	•		
	Sta Registr		31. Date filed (Month, Day, Year) APR 0	6 2005 32. Regi	trar's Signatu		La. v							

		1 - For State of Maryland / Department / Department / Department / Department / Department / Dep	artment of Health and Martificate of Death	Mental Hygier	0000 10000
Physi	cian	Decedent's Name (First, Middle, Last)     Helen Jones Moreland		2. Date of Death Month	2005 3. Time of Death 3. 2005
/Med	lical	neten bones morerand	4b. City, Town, or Location of Death		2005   625A M
Exam	iner	Solomons Nursing Center	Solomons		Calvert
Funera Directo		5. Social Security Number 229 03 9060 6. Sex 1 M 2 F 83 Yrs.	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Yea May 3 19	9. Birthplace (State or Foreign Country) 21 Virginia
Maryland -fehow	tor	Usual Residence of Decedent  10a. State  10b. County  Maryland  St. Mary's  10c. City, Town or Lo  Lexington			10d. Inside City Limits 1 ☐ Yes 2 ☒ No
h with the 23e or 28e	Funeral Director	10e. Street and Number 22815 Maple Road	10f. Zip Code 20653	10g. (	Citizen of What Country? United States
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If Item 27 is marked other then "natural", or Items 23e or 28e-f ehow any injury or other treumetic event, Its Medical Erani har must be notified at	þ	3 ☐ Widowed 4 ☐ Divorced Year or Dates:	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☑ No Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: White
within 72 ho	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0·12)  College (1-4or 5+)	dent's Usual Occupation kind of work done during most of work DO NOT use retired)  emaker	ring 16b.	Kind of Business/Industry
uld be filed fental Hygierkad other fic event,	To Be Co	17. Father's Name (First, Middle, Last)	18. Mother's Nam	e (First, Middle, Maide Rebecca	own home on Surmame) Coggsdale
ind 2 shou alth and M 27 is mai			ng Address (Street and Number or Rur  Mill Swamp Road		
Pages 1 and of He and of H		20a. Method of Disposition 20b. Place of Dispo	osition (Name of matory or other place)  April 11  Memorial Gardens	Date 20c.	Location - City or Town, State Treake Virginia
permit. Departi		15 5. 5itt	25 Academy Ave. Portem	ing Funeral H ith Virminia	tane
Physiciar /Medica Examine	1	23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence of):	Section 1	or respiratory arrest,	Approximate Interval Between Onset and Death
ported by executed physician and sthe burial-transit	dical Examiner	d	Tag as	7	
the death certifical y the attending phy ched for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregrant in the past 12 morths? 1  Yes 2  4 Pregnant at time of death 5 9 Unknown	Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
w requires that the de been signed by the should be detached	by	Part II. Other significant conditions contributing to death but not resulting in the ur	nderlying cause given in Part I.	23e. Did tobacco	o use contribute to the cause of death? 2 No 3 Probably 4 Minknown
sicien: Tha law re scertificate has bee lirector, page 2 sho	Completed		cione	24a. Was an autopsy performad? 1 ☐ Yes 2	24b. Were autopsy findings available prior to completion of cause of death?  1 □ Yes 2 □ No
ng Phy After this	ation; To Be	1 ☐ Yes 2 ☐ No Hospitai: 1 ☐ Inpatient 2 ☐ ER/Outpatien	nt 3 DOA Other: 4 Xursing Ho	h (Check only one) me 5 Thesidence 28d. Describe how inj	6 ☐Other (Specify) ury occurred
tel or Atters after de al Diracto	Certification;			City or Town, Sta	
To the Hospitel or Attendi within 24 hours after death. To the Funeral Diractor: A completely filled in by the to	Medical	29a. Certifier  (Check only one)  Certifying Physician: To the best of my knowledge, death a control of the death of the d	vestigation, in my opinion, death occurr	red at the time, date ar	nd place, and due to the cause(s)
Mill Too	×	A Trundy comey Physic	29c. License number  19427	4	ate signed (Month, Day, Year)
2	state			rures Fr	edon ( M) 20678
Regis		31. Date filed (Month, Day, Year)  APR 1 2 2005	Sparke		

		-	For St = State Ragistrar	ate of Marylan		artment o				giene Reg. No.	)5	13973
			Decedent's Name (First, Middle, Last),		-				2. Date of De			3. Time of Death
	Physicia	n	Betty Belle	no	ats				April	Day 13	2005	08:40 M
ķ.	/Medic		4a. Facility Name (If not institution, give street			4b. City, To	wn, or Loc	cation of Death			nty of Death	
1	Examin	er	Washington County Ho				gerst			Washi	ington	
	Fundadal		5. Social Security Number 6. Sex	7. Age (In yrs.	last birthday)	If Under 1	Year If	Under 24 Hrs.	8. Date of Bir	th		place (State or Foreign intry)
	Funeral Director	i	217-28-6917 <sup>1□ M</sup>		3 Yrs.	Months D	Days H	lours Min.	(Month, Da Aug. 18	y, Year) .1931		ryland
		-	Usual Residence of Decedent						1	, , , , , , ,		
	yland		10a. State 10b. County	10c. Cit	y, Town or Lo	ocation						10d. Inside City Limits
	Mar Fied	ţ	Maryland Washingto	on		Hagers	stown	l				1 ☐ Yes 2 🕅 No
	r 28g	lrec	10e. Street and Number			10f. Zip Co	ode			10g. Citizen	of What Cou	intry?
	tied within 72 hours after death with the Maryland Hygiene. Ither than "natural", or items 23s or 28s-f show ent, the Macical Examiner must be notified at	Funeral Director	9644 Downsville Pike	2			21	.740		Ţ	JSA	
	ms ?	Der		Vas Decedent Ever in U	.S. 13.	Was Deceder	nt of Hispa	nic Origin? (S	pecify Yes or No o Rican, etc.)	- 14. F	lace - Amer Black, White	
ဖ	after or ite	Ī	1 Never Married 2 Married 1	☐Yes 21∑No fYes, Give		1 □ Yes 2 Ø		Specify:	o i noun, oto.,	Spe		white
21215-0036	ral',	þ	3 ☐ Widowed 4 ☐ Divorced	ear or Dates:		10103 22	3110 3	pocity.		Зре	cny.	
5	72 h	Completed	15. Decedent's Educatio (Specify only highest grade cor		(Give	dent's Usual (	done duni	n ng most of wor	king	16b. Kind of	Business/I	ndustry
2	ithin	npidu	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use	retired)					
	filed w Hygier sther th	ပ္ပ	12	0	sec	retary	1		(F) . M(14)		untin	g
nd	tal H d oth	Be	17. Father's Name (First, Middle, Last) Leo Henson				18		ne (First, Middle Doffont		iame)	
<u>ya</u>	should be nd Mental marked c	2							Poffent			
Maryland	0 6 8 8		19a. Informant's Name/Relationship (Type, F		1	•			ral Route Numb	-		
≥,	1 and 2 Health tem 27		Robert M. Moats - hu					Te Pike	e, Hager			
ore	of H of H if iten		20a. Method of Disposition  1 □ Burial 2 ☒ Cremation 3 □ Remo	val from State	emetery, cre	osition (Name matory or othe	er place)		Date	20c. Locatio	on - City or i	own, State
Ĕ	Pag ment ant: I		* 4 □ Donation 5 □ Other (Specify)	Hag	gersto	wn Cren	nator	y   4-1	5-05	Hagers	town,	Maryland
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		21. Signature of Funeral-Service Licensee	nn.	12	Name and	Address o	f Facility	MINNIC	CH FUNE	RAL H	OME
<b>m</b>	89 5 9		20 all 11	11/4m	rud	415 E	E. Wi	lson B	lvd., Ha	gersto	wn, M	d. 21740
			23a. Part1. Enter the disease, or complication shock, or heart failure. List only one care	ons that caused the deat ause on each line.	h. Do not en	ter the mode of	of dying, s	uch as cardiad	or respiratory a	rrest,		Approximate Interval Between
0	Physician		Immediate Cause (Final disease or condition	Cardiac	Anna	+						Onset and Death
1	/Medical		resulting in death)	Due to (or as a consec	uence of):			0				
	Examiner		Commence the line conditions	Athenose	erotic	Card	iou	rescul	an Dis	ecuse		years
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consec	juence of):	1		001				
	be executed sician and burial-transit	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events  c	Type 2	Die	beter	2 1	tellet	us_			yeous
ó	an ar irial-t		resulting in death) Last	Due to (or as a consec	juence of):							•
8760,	death certificate be executed e attending physician and of for use as the burial-transit	Physician/Medical	d									
9	tifica ng ph as th	Ned	15.55441.5									
Вох	eath certific attending p	A/UE	23b. was decedent pregnant	f yes, outcome of pregn 1 ☐ Live birth 2 ☐ Feta	ancy al death 3[	⊒Ectopic preg	nancy				Date of delin	•
	deat	sicie	1 Yes 2 No	4 ☐ Pregnant at time of o		Other (spec					Month	Day Year
P.0	that the de led by the a detached	hy	9 Unknown	JEI OTIKTOWT								
	res tha igned be de	by F	Part II. Other significant conditions contribution	uting to death but not res	sulting in the u	ınderlying cau	ise given i	n Part I.		/		the cause of death?
rd	w require been sig should t	ed	Hyperlipide	ma					1 🗹	Yes 2□No	3  □ Pro	bably 4 Unknown
ပ္ပ	law requires as been sign 2 should be	olet	Perioheral	lascular	Dis	20021			24a. Was		b. Were aut	topsy findings available omptetion of cause of
Vital Records,	0 5 0	Completed	Constantino	ila Die	2000	,			perfo	2 No	death?	2□ No
ta	ician: Th certificate rector, pag	Φ	25. Was case referred to medical	- CO C C C C C C C C C C C C C C C C C C			26	6. Place of Dea	ath (Check only			
>	Physician: this certific ral director,	To B	examiner? 1 ☐ Yes 2 ☑ No Hosp	ital: 1 ☐ Inpatient 2 ☑	ER/Outpatie	nt 3 DOA	Other:	4 Nursing H	lome 5 Resi	dence 6 🗆	Other (Spec	rify)
of				8a. Date of Injury (Month, Day Year)	28b. Time o	of 280	c. Injury at Work?		28d. Describe	how injury oc	curred	
Division	Attending Indeed to death.	atlo	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day 1 day)	injury	м		2 □ No				
N S	I or Attendi after death. Director: A I in by the fu	ific	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 2	8e. Place of Injury - At h building, etc. (Speci	ome, farm, st	reet, factory,	office		28f. Location (	Street and Nu wn, State)	imber or Ru	ral Route Number,
Ö	al or s afte	Certification:	TIOMEIU	ballarig, etc. (opeci	'97					,,		
	To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by		29a. Certifier 1 Certifying Physicia									
	ne Ho n 24 ne Fu nietel	edicai	(Check only 2 Medical Examiner: one)	and manner stated.	ation and/or in	ivestigation, ii	n my opini	on, death occi	irred at the time,	date and plac	se, and due	to the cause(s)
	To the within 2 To the complet	ž	29b. Signature and little of certifier	01		29c.	License ni	umber		29d. Date sig	ned (Month	, Day, Year)
			1/1/ス分	8h wo		F.	58	3810		APRIL	15	2005
			30. Name and address of person who compl	eted cause of death (Ite	т 28а) (Туре		0.1		• 1		1	
ĆŁ	1-5		STEVEN BLASH MO	324 East A	nteta	u St	Duit	5 Se3	Hage	13 tow	MU	21740
	Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature	La. His			)			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month 1:20 PM 2005 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Sa 1150W WICOMICO OSDICE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2□ F Yrs. Director 79 March 27,1926 MD Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" --- any injury or other fraumatic average. 10a State 10h Counts 10c, City, Town or Location 10d. Inside City Limits Completed by Funeral Director 1 ☐ Yes 2X No MD Worcester Ocean City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13335 Nantucket Rd. 21842 US 12. Was Decedent Ever in U.S. Armed Forces? 1XYes 2 □ No WWII 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1X Never Married 2 Married If Yes, Give Year or Dates: 1 ☐ Yes 2 XNo Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Electrician Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Leonard Morris, Sr. ပ Irma Parker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) April Marcantoni (Personal Rep) 1109 Primrose Ct., Annapolis, Md. 21403 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Jerusalem Cemetery 4-16-05 Parsonsburg, Md. 22. Name and Address of Facility The Burbage Funeral Home 108 William St., Berlin, Md. 21811 23a. Park Enter the disease, or complications that odused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner g physician and as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical attending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an perfor Division of Vital To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death Check on one examiner2 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes atient 2 ER/Outpatient Certification: To 3 DOA this 27. Manner of Death 28a. Pate of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation Diractor: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide vithin 24 hours
ha Funeral D' Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner state. (Check only one) 29b. Signature 29c. License number title of certifier 29d. Date signed (Month, Day, Year,

G'H' 9+1

State Registrar

tte filed (Month, Day, Year)
APR 13 2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2. Pogistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2005 April **Physician** Joseph James NANDOR 10, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 13526 Paradise Drive Washington Hagerstown If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. July 3, 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral**  Birthplace (State or Foreign Country) 1X M 2□ F 75 203-22-4161 Pennsylvania Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. Ither than "natural", or itema 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 7 is marked other than "natural", or itema 23a or 28a-f show traumatic event, it a Modical Examination maillied at 10d. Inside City Limits 1 ☐ Yes 2 TWo Hagerstown Director Maryland Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13526 Paradise Drive 21742 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Armed Forces?

1 Yes 2 No If Yes, Give 1948— 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 ☐ Never Married 2 Married If Yes, Give 1948— Year or Dates: 1952 Specify: white 1 ☐ Yes 2 X No Specify: 2 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 0-12 College (1-4or 5+) engineer crane manufacture Pages 1 and 2 should be filed vent of Health and Mental Hygie int: If Item 27 is marked other t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Andrew Joseph Nandor Anna Dzugan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sue Nandor - wife 13526 Paradise Drive, Hagerstown, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State ō permit. Page Department of important: If any injury or \* 4 ☐ Donation 5 ☐ Other (Specify) Rose Hill Cemetery Harerstown, Maryland 21. Signature of Eugeral Service Licenses 22. Name and Address of Facility Minnich Funeral Home 415 East Wilson Blvd., Hagerstown, Maryland 21740 23a. art1. Enter the disease, or co plications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Due to [or as a consequence of] Examiner If any leading to immedicause. Enter Underlying Cause (Disease or injury The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown signed by t Id be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 Yes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? certificate 1 Yes 1 ☐ Yes 2 ☐ No 2110 Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one examiner Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 ☐ No this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation after death Director: / 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral D 1 Contifying Physician: To the best of my howledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical one)\_ 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number ddress of person who completed cause of death (Item 23a) (Type, Print) 111

State Registrar 31. Date filed (Month, Pa

Year)

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Registrar's Signature

		1 - State of Marylan		artment of rtificate of			iene	13976
Physicia	an	1. Decedent's Name (First, Middle, Last)  Helen Virginia NOLA	ND			2. Date of Death April 9,		3. Time of Death 9:30a.M
/Medic Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town,	or Location of Death		4c. County of Deat	
		11010 Clinton Avenue			gerstown			ngton
Funeral Director		5. Social Security Number 6. Sex 1 ☐ M 2 ☑ F 7. Age (In yrs. 8 Usual Residence of Decedent		If Under 1 Yea Months Days		8. Date of Birth (Month, Day, May 18,	Year) 9. Bird Co	thplace (State or Foreign buntry) Urginia
yland			y, Town or Lo	cation				10d. Inside City Limits
ne Mar ≱8a-fs	ector		erstow					1 ☐ Yes 2大 No
with the or 2	Funeral Directo	100. Street and Number 11010 Clinton Avenue		10f. Zip Code	21740	10	Og. Citizen of What Co U.S.A.	ountry?
death	nera	11. Marital Status 12. Was Decedent Ever in U Armed Forces?	S. 13.		Hispanic Origin? (Sp ban, Mexican, Puerto	pecify Yes or No-	14. Race - Ame	
Baltimore, Maryland 21215-0036  permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mentall Hygiene. Important: If time 27 le marked other then "natural", or items 23s or 28s-f show any Injury or other traumatic svent, the Modical Evants or must be notified anones.	by Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 12 No If Yes, Give Year or Dates:	į.	1 ⊡ Yes 2⊠ No		o nican, etc.)	Black, Whit	•
5-0	eted	15. Decedent's Education (Specify only highest grade completed)	16a. Deced (Give	dent's Usual Occu	upation e during most of won red)	king 1	16b. Kind of Business/	Industry (Industry
within within then then	Completed by	Elementary/Secondary (0-12)		nurse	'ea)		doctor's	office
e filed al Hygi other	Be C	17. Father's Name (First, Middle, Last)			18. Mother's Nam	ne (First, Middle, M		
ylar ould b Menta	ToE	James B. Hovermale					Tevault	
Mar d 2 sh th and 7 le m traum		19a. Informant's Name/Relationship (Type, Print)  Linda Ann Mumma – daughter					City or Town, State, 2 wn, Maryla	
re, lang the litem 2		20a. Method of Disposition 20b. F		sition (Name of natory or other pl		Date 2	20c. Location - City or	
Page Page nent o ant: If		La Bullat 2 Coloniation 3 Chemoval nom State		1 Cemete	ADI	11 2005 I	Hagerstown	, Maryland
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours alt Department of Health and Mehalt Hygiens. Important: If item 27 le marked other then "natural; or any Injury or other traumatic svent, the Medical Exercions.		21. Signature of Euroral Service Licensee		Name and Add			Funeral Ho erstown, M	me aryland 2174(
ate be executed  Thysician and the burial-transit t	icai Examiner	shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to it as a consequence of the conditions of the con	uence of):	fareho	Α			Interval Batween Onset and Death In Income
Division of Vital Records, P.O. Box 68760, To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.  To the Funerel Director: Attent his certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown  23c. If yes, outcome of pregnat 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of december 2 of the pregnant at time 2 of the pregnant at time	Ideath 3	Ectopic pregnan Other (specify)	су		23d. Date of del Month	ivery Day Year
ds, P	by	Part II. Other significant conditions contributing to death but not res	ulting in the u	nderlying cause g	given in Part I.	23e. Did tob	acco use contribute to s 2€No 3 🗆 Pr	the cause of death?
Vital Record. Icien: The law require certificate has been sirector, page 2 should I	Completed						prior to death? No 1 □ Yes	itopsy findings available completion of cause of
f Vit nyelcler nis certil	To Be	25. Was case referred to medical examiner?  1 Yes 2 No Hospital: 1 Inpatient 2	ER/Outpatier	it 3 DUA	ther: 4 Nursing H	th <i>(Check only one</i> ome 5 <b>X</b> Resider	nce 6 □Other <i>(Sp</i> e	cify)
ing Pl		27. Manner of Death  1 Natural 5 □ Pending 28a. Date of Injury (Month, Day Year)	28b. Time of Injury	W		28d. Describe how	w injury occurred	
ivisic or Attend fler death Director:	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Injury - At huilding, etc. (Specif	ome, farm, str V)		⊒Yes 2□No e	28f. Location (Str. City or Town,	eet and Number or Ru State)	aral Route Number,
Division of Vital Rewinding Physicien: The Mayin's 4 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical Ce	29a. Certifier  (Check only one)  29 Medical Examiner: On the basis of examina and manner stated	wledge, death	n occurred at the vestigation, in my	time, date and place, opinion, death occur	and due to the car	use(s) and manner as ite and place, and due	s stated. to the cause(s)
o the vithin 2 to the comple	Mec	29b. Signature and title of certifier 2		29c. Licer	nse number	29	d. Date signed (Monti	h, Day, Year)
		Dry A William m	D	D19	755		4/9/05	5
- 411.41		30. Name and address of person who completed cause of death (Iten	23a) (Type,		11	14	4/9/03 ms Z	1747.
3H-4 Sta	to	31. Date filed (Month, Day, Year) 32. Registrar's Signa	ture	Le 228	Hage	rstown	1m). 2	1170
Registr		APR 11 2005	A. A	Carlo				

		1	For State Registrar	State of	Marylan		artment of H		•	giene Reg. No. 🔿	PM 475	
	/sicia	n	Negatian     Decedent's Name (First, Middle, La     William McKinley		S Jr.				2. Date of De Month		105 2005	3. Time of Death
	ledica amine		4a. Facility Name (If not institution, giv Washington Count				4b. City, Town, or Hagers				nty of Death ashing	ton
Fund Direct			213-07-4234	ex IXM 2□F	7. Age (In yrs. 88	last birthday Yrs.	If Under 1 Year   Months   Days	If Under 24 H Hours Mi		ıy, Year)	Cou	place (State or Foreign ntry) yland
death with the Maryland ims 23a or 28e-f show	fied at		Usual Residence of Decedent  10a. State  10b. County  Maryland  Wash:	ington	10c. Cit	y, Town or L	ocation Hagers	town		_ ,		10d. Inside City Limits 1 ☑ Yes 2 ☐ No
th with the	ist be no	Funeral Director	10e. Street and Number 1008 Linwood Roa	ad			10f. Zip Code 217	40		10g. Citizen	of What Coul	ntry?
If E, INALYICATION IN INC.	EXECTION	ģ	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☑ Widowed 4 ☐ Divorced	12. Was Dece Armed For 1 X Yes If Yes, Give Year or Da	ces? 2 ∏ No e	.S. 13.	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☒ No	ispanic Origin? in, Mexican, Pu Specity:	(Specify Yes or No erto Rican, etc.)	E	Race - Americ Black, White, c <i>ify:</i> Wh	
within 72 ho ene. than "natur	ne Medical	Completed	15. Decedent's E (Specify only highest gr. Elementary/Secondary (0-12)	ducation ade completed) College (1-	4or 5+)	(Giv	edent's Usual Occup e kind of work done o DO NOT use retired meter re	during most of w ()	vorking		Business/In	ndustry
rked other	tic event, I	To Be Co	17. Father's Name (First, Middle, Last William M. Nicho						ame (First, Middle, ces Will:		ame)	
and 2 shore ealth and N	er traume		19a. Informant's Name/Relationship (			307	S. Conoco		St., Wil	lliamsp	ort, l	Md. 21795
Page ment c	any injury or otl 2000.		20a. Method of Disposition  1	fy)	State	emetery, cre Zion	osition (Name of omatory or other place U. M. Ce	metery	Date 4/16-05	Myers	on - City or To	
partit. Departition	any i		23a. Part1. Enter the disease, or con-	M///	MMM.	Le X		lson Bl	MINNICH I vd., Hage iac or respiratory a	erstowi		Approximate
Physic /Med	ical		shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a L( y	ras a consec	uence of):	1 -	1 0				Interval Between Onset and Death
Exami		Examiner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. QCC Due to (c	or as a consecutive of the conse	-	winas	1 Tri	6C( IV	fect	ion	
ortificate be executed thing physician and	the burial-tr		resulting in death) Last	Due to (	CCYY	uence of):	el Arvi	J F	ibrille	Tan	\	
Geath certifi e attending	ched for use as	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown		inth 2 ☐ Feta ant at time of o	Il death 3	□Ectopic pregnancy □ Other (specify) _	Montage			Date of delive	ery Day Year
	uid be deta		Part II. Other significant conditions	contributing to de		-	underlying cause giv	en in Part I.		robacco use c Yes 2 □ No		he cause of death? bably 4 □Unknown
I KeC The law ate has b	page 2 sho	Completed	Denydrai	con					24a. Was auto perfo		b. Were auto prior to co death? 1 \( \text{Yes}	opsy findings available ompletion of cause of
P by O	eral director,	To Be	25. Was case referred to medical examiner? 1  Yes 2  No 27. Manner eath	28a. Date o	npatient 2	28b. Time	of 28c. Injur	er: 4 🗌 Nursing	Death (Check only of Home 5 Resi	dence 6 🗆		fy)
DIVISION i or Attending after death. Director: After	in by the fun	Certification:	1   fatural   5   Pending investigation   3   Suicide   4   Homicide   5   Pending investigation   5   Pending inv	on 28e. Place	h, Day Year) of Intury - At h	Injury ome, farm, s fy)		Yes 2 1 Mo	28f. Location ( City or To		mber or Rur	al Route Number,
ppitei ours a	completely filled	edical Ce	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	hysicien: To the miner: On the ba and mann	isis of examina	owiedge, dea ation and/or i	ath occurred at the tir investigation, in my o	ne, date and pla pinion, death oc	ace, and due to the ccurred at the time,	cause(s) and date and plac	manner as s ce, and due t	stated. o the cause(s)
To th withir To th	сошо	Me	29b. Signature and title of certifier  France ©	Duise	000	+(aspii	e(s) 29c. Licens	e number	7	29d. Date sig		-
5H-12	,		30. Name and address of person who  Free CLS ( > A-  31. Date filed (Month, Day, Year)	Dani	e of death (tter	DD	as( E	. Ani	iestun	51,	MOS	, 2005 1905 pown, 21748
Re	Sta gistr	ar	APR 15	2005	allow a	1. 16	peter					

DHMH 17 Rev 1/2001

			1- State of		artment of Health ar	, ,	giene leg. No. O O O O
			Decedent's Name (First, Middle, Last)			2. Date of Dea	th 3. Time of Death
П	Physici		Donna Mae Patte	rson		APRIL	8, 2005 4:15P. M
	/Medic Examin		4a. Facility Name (If not institution, give street and nur		4b. City, Town, or Location of	Death	4c. County of Death
	LAGITIT	Ģ.	8644 SEDLEY COURT		GAITHERSBUR	G	MONTGOMERY
	Funeral			7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Months Days Hours	Hrs. 8. Date of Birth Min. (Month, Day	9. Birthplace (State or Foreign Country)
	Director		360-36-8936 1□ M 2፟ØF	57 Yrs.	Months Days Hours	April 1	5 1947 Illinois
	pu >		Usual Residence of Decedent  10a, State 10b, County	10c. City, Town or Lo	antina		10d. Inside City Limits
	anyla shov	2	Maryland Montgomery	Gaithersh			1 ☐ Yes 2X No
	Ne W	Director	10e. Street and Number		10f. Zip Code		10g. Citizen of What Country?
	ath with the Marylan 23a or 28e-f show		8644 Sedley Court		20879		United States
	72 hours after death with the Maryland natural', or Itams 23a or 28e-f show diest Examinat must be nutified at	Funeral		dent Ever in U.S. 13. V			
	ours after dea rai', or itams	Ë	Armed Fo  1 ☐ Never Married 2 🕅 Married 1 ☐ Yes	2 X No	Was Decedent of Hispanic Origin f Yes, specify Cuban, Mexican,	Puerto Rican, etc.)	Black, White, etc.
936	urs aft	by	3 ☐ Widowed 4 ☐ Divorced	e 1	I ☐ Yes 2 ☑ No Specify:		Specify: White
Maryland 21215-0036	d within 72 hours jiene. r then "natural", Ine Madical Exe	Completed	15. Decedent's Education		lent's Usual Occupation kind of work done during most of	d madein a	16b. Kind of Business/Industry
ਨੁੱ	within 7 ene. then "r	ed (	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1	ar working			
7	filed withi Hygiene. Ithar then	Son	12		stant Manager		Retail Store
p	0 = 0 >	Be (	17. Father's Name (First, Middle, Last)			s Name (First, Middle,	Maiden Sumame)
<u>yla</u>	should by nd Menta marked imatic ay	2	Clifford Everson		H	lelen Pecko	
<u>a</u>	2 sho and is ma		19a. Informant's Name/Relationship (Type, Print)		•		r, City or Town, State, Zip Code)
	and ealth m 27 her tu			-			rg, Maryland 20879
9	Pages 1 and 2 should b nent of Health and Ments int: if itam 27 is marked iry opother traumatic a		20a. Method of Disposition 1 □ Burial   ② Cremation 3 □ Removal from	20b. Place of Dispo cemetery, cren	natory or other place)   A	pril 10,	20c. Location - City or Town, State
<u>=</u>	Pa tmen tant:		` 4 ☐ Donation 5 ☐ Other (Specify)			2005	Alexandria, Virginia
Baltimore,	permit. Page Department of Important: if any injury of once.		21. Signature of Juneral Service Lisensee		. Name and Address of Facility		
	70 = 8 Q		23a. Part1. Enter the disease, or complications that c				ersburg, MD 20877  Pest. Approximate
	/Medical Examiner	Examiner	Sequentially list conditions, b. Due to cause. Enter Underlying Cause (Disease or injury	or as a consequence of):	Street	of Cuth	Onset and Death
. Box 68760,	The law requires that the death certificate be executed the has been signed by the attending physician and tage 2 should be detached for use as the burial-transit	Physiclan/Medical Exar	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Ves. 2 12b. 4 Pregn	ant at time of death 5	Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
P.0	at the de by the a tached	hys	9 ☐ Unknown 9 ☐ Unknown	/WIT			
	w requires that been signed should be del	by	Part II. Other significant conditions contributing to de	ath but not resulting in the ur	nderlying cause given in Part I.		bacco use contribute to the cause of death?  es 2 No 3 Probably 4 Munknown
Records,		Completed				24a. Was a autops perfor	sy prior to completion of cause of
Vital	ician: Tertifical	Be (	25. Was case referred to medical examiner?			f Death (Check only or	ne)
o Jo	Physician: r this certific ral director,	ို	1XX es 2 No Hospital: 1 □ I	npatient 2 ER/Outpatien			ence 6 XOther (Specify)
		on:	1 - I tatulal 5 - I onding	of Injury h, Day Year) 28b. Time of Injury	Work?	Calh	t cut it to belief
sio	Attanding r death. sctor: After by the fune	cat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 28e Place	4-18 105 Touch 16.00			auts from
Division		ertification;	determined 288. Place	of Injury - At home, farm, str ng, etc. <i>(Specify)</i>	eet, factory, office	City or Town	treet and Number, or Rural Route Number, n, State) 76 4 Seally ( with
_	Hospital or 94 hours afte Funeral Dira tely filled in b	O	29a. Certifier 1☐ Certifying Physicien: To the	host of my knowledge death	Occurred at the time state and	place and due to the	up, hayland
	e Hospital 24 hours a Euneral letely filled	edical	(Check only one) (Check only one) (Check only one)	asis of examination and/or inv	vestigation, in my opinion, death	occurred at the time, d	a we (s) and manner as stated. late and place, and due to the cause(s)
	To the Hospital or within 24 hours after To the Funeral Director completely filled in	Mec	29b. Signature and title of certifier		29c. License number		29d. Date signed (Month, Day, Year)
1	H ≯ F 8		11/11/11/		OCME		APRIL 9,2005
•	5		30. Name and address of person who completed caus	e of beath (Item 23a) (Type,		F	TRIL 9,2007
			So. realle and address of person who completed caus	5 5. 25 att. (116111 252) (1908,	111 PENN	STREET, BAL	TIMORE, MARYLAND 21201
	Sta	te	31. Date filed (Month, Day, Year)	egistrar's Signature	. P. 0		
	Regist		APR 11 ZUUS Ka	egistrar's Signature	MES		

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1 Decedent's Name (First, Middle, Last) Month Day Year **Physician** April 0405 AM 2005 /Medical Florence Viola Potts 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Washington County Hospital Hagerstown Year | If Under 24 Hrs Washington 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Days Hours Months 1 ☐ M 2 ☐ XF Yrs 95 Director Dec.27,1909 Maryland 219**-**14-7527 Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a, State or 28a-f show other traumatic event, the Medical Examinan, ust be notified at 1 Yes 2 No Director Washington Williamsport Maryland 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code death with or Items 23a <u> 15221 Clear Spring Rd.</u> 21795 USA Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If tiem 21 is marked other than "natural", or flen any injury or other traumatic avant. 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify by. Specify: 3 X Widowed 4 Divorced White Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 Laborer <u>Aircraft Manufacturer</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George Washington Crist Mary Smith 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 21503 Black Rock Road Hagerstown, Maryland <u> Richard Martin - Son In Law</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Date 20c. Location - City or Town, State 4 Donation 5 Other (Specify) Greenlawn Mem. Park Apr.12,2005 Williamsport, Maryland Geogral Service 21. Signatur OSBOTHE FURSEFACTIVHOME, P.A. (4) 425 S. Conococheague St. Williamsport.MD 21795 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onser and Death shock, of heart failu Immediate Cause (Final disease or condition resulting in death) Pnysician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (usease or injury that initiated events resulting in death) Last Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 2 Fetal death 3 Ectopic pregnancy Month Day 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No the detached 9□ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 - No To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 1 🗌 Yes 2 2 ☐ ER/Outpatient 3 ☐ DOA a after death.

I Director: After this of in by the funeral d 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manna et Death 28a. Date of Injury Certification; (Month, Day Year) Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide within 24 hours a To the Funeral 🗠 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and April 10, 2005 30. Time and address ompleted cause of death (Item 23a) (Type, Print) Antie 32. Régistrar's Signature State Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) April 7, **Physician** 2005 3:49 P M Ann Ridenour /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Frederick Thurmont Kelbaugh Road 16174 8. Date of Birth (Month, Day, Year) Jan. 13, 1925 If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number Funeral Days 1□M 241F Mary land 80 213-24-7738 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d, Inside City Limits 10a State 10b. County or 28a-f show ? Is marked other then "natural, or items 23s or 28s-f shov traumatic event, the Marked Examinar must be notified at 1 ☐ Yes 2 ☐ No Directo Thurmont Frederick Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21788 IISA 16174 Kelbaugh Road filed within 72 hours after death Hygiene. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. ☐Yes 2 XNo Yes. Give 1 □ Never Married 2 □ Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: Specify If Yes, Give Year or Dates: δ 3 ₩idowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) College/Seminary Dining Room Waitress Unknown 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 should be fit and Mental H Krietz Cecil 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 st ment of Health and tant: If itam 27 is r 8404 Hemler Road, Thurmont, MD 21781 Ed Ridenour/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) permit. Pages Department of Important: If it any injury or o Blue Ridge Cemetery 4/11/2005 Thurmont, MD 22. Name and Address of Facility Stauffer Funeral Home, 104 E. Main Street, Thurmont, MD 21788 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, the cause on each line. 23a. Pur Enter the dis ase, shock, beart failure. List Approximate Interval Between Onset and Death Immediate Cause (Final Therosclerotic Cardiovascular Disease Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury is a consequence of): Examiner The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last the attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Dav 4☐Pregnant at time of death 5 Other (specify) signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ peq bstructive Polmonar 2 No 3 Probably 4 Unknown Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an funeral director, page 2: autopsy certificate 1 ☐ Yes To the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) aminer Hospital: Other: 4 Nursing Home 5 esidence 6 Other (Specify) 1 Yes ٩ 2 🗌 No 1 Inpatient 2 ER/Outpatient 3 DOA this Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification; After 1 Nature.
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death. 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical completely within 2. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number npleted cause of death (Item 23a) (Type, Print) 32. Registrar's Signature Registrar

DHMH 17 Rev 1/2001

			For State Registrar		State	e of Ma	aryland	-	artmen			and Me	ental Hy	giene	HALL	130	181
			Decedent's Name (F	First, Middle,	Last)								2. Date of De	ath		3. Time of	of Death
н	Physicia		Elba	Elena	a Ga	allaı	do	Rot	h				April	9 Day	2005 Year	1:30	РМ
	/Medic Examin		4a. Facility Name (If no	ot institution,	give street an	d number)			4b. City,	Town, or	Location of	f Death		4c.	County of Dear	th	
П			Calvert Me	emorial	L Hosp						Fred				Calver	t	
	Funeral		5. Social Security Num	iber 6	i. Sex 1 □ M 21⁄2			ast birthday)	If Under Months	1 Year Days	If Under a	Min.	8. Date of Bir (Month, Da		Co	hplace (State untry)	or Foreign
	Director	-	none Usual Residence of De	ecedent			88	Yrs.				!	May 17	, 19	16   Chi	.le	
	land			0b. County			10c. City	, Town or Lo	cation							10d. Inside (	City Limits
	Mary -feh	ţō	MD	Calver	+				Nor	th E	3each					1 <b>X</b> Ye	s 2 No
	r 28e	irec	10e. Street and Number						10f. Zip					10g. Citi	zen of What Co	ountry?	
	th wit	ai D	9019 Bays	ide Ro	ad					2	20714		=		Chile		
	eme	Iner	11. Marital Status			Decedent led Forces?	Ever in U.S	S. 13.	Was Deced	dent of Hi cify Cuba	spanic Ori	gin? (Spec i, Puerto R	cify Yes or No lican, etc.)	)-	14. Race - Ame Black, Whit		
36	within 72 hours after death with the Maryland ene. than "natural", or iteme 23e or 28e-f ehow the Madical Examinar must be notilised at	by Funeral Director	1 Never Married	_	If Ye	Yes 2∭X1 s,G <u>i</u> ve	10		1 Yes	2 🗆 No	Specify:	ol. / 1 .			Specify:		
21215-0036	hours tural',	q p	3 XWidowed 4 [			or Dates:		16a. Dece	dent's Heur	Al Occupa		Chile	ean	16h Kir	MI nd of Business	nite	
15	n 72 n "nai	Completed	(Specify	5. Decedent's only highest	grade comple			(Give	kind of wo DO NOT u	rk done a	furing most	t of workin	g	100. KII	id of business	industry	
12	iene.	omp	Elementary/Secondary (0-12) College (1-4or 5+) 8 homemaker own 1											wn home	9		
b	illed Hyg other	Be C	17. Father's Name (Fin	rst, Middle, La	ist)						18. Mothe	r's Name	(First, Middle	. Maiden	Sumame)		
<u>a</u>	Ald be Aenta rked ric ev	To B	Abel			(	Galla	.rdo			Enr	iquet	a		(	Dyarzo	
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Importent: if Item 27 is marked other than "natural; or Iteme 23a or 28e-1 ehow any injury or other treumatic event, the Madical Examinatory at the notified at ODGs.		19a. Informant's Name	e/Relationshi	р (Турө, Print	")			-					-	r Town, State,		_
Σ	and 2 palith n 27 i		Sylvia E.	Young,	daug	hter					r Ct.				ach, MI		32
Baltimore,	of He		20a. Method of Dispos 1 ☐ Burial 2 💢 0		Bemoval:	from State	20b. PI	lace of Dispo emetery, crei	nsition (Nar matory or o	ne of ther place	e)	Da	ite	20c. Lo	cation - City or	Town, State	
Ĕ	Pag ment ent: 1 ury o		`4 □Donation 5			nom otato	Met:	ropoli	tan (	rema	atory	4–11	-05	Alex	andria,	, VA	
Salt	Depart Import any inj		21. Signature of Fune	ral Service Li	censee			22	2. Name ar	d Addres	s of Facilit	У					
_	20 E 8 9		Mulle	mot	> 0/4	22							P.A.		wings,		736
			23a. Part1. Enter the shock, or heart for	ailure. List of	nly one cause	on each li	10.		er the mod	e or ayını	g, such as	cardiac or	respiratory a	rrest,		Approxima Interval Be Onset and	itween
	Physician		Immediate Cause (Fir disease or condition resulting in death)	nai	_ a P	NE	MOI	VIA								PAT	5
ŀ	/Medical Examiner		roodining in double,	Ĭ	Du	e to (or as	a cons <del>e</del> qu	uence of):									
		-	Sequentially list condi	itions, ediate	b. — Du	ie to (or as	a consequ	uence of):									
Т	rted nsit	Examiner	cause. Enter Underly:	ing 🚄	<u> </u>	•											
,	execu n and iat-tra	Еха	that initiated events resulting in death) Las	st	C. Du	e to (or as	a consequ	uence of):									
68760	ate be executed hysician and the buriat-transit	cail			d												
68	tificat ng phy as th			_	0.00												
Вох	death certifica e attending ph id for use as th	N/UE	IF FEMALE: 23b. Was decedent pr			s, outcome Live birth			□Ectopic pr	egnancy				2	23d. Date of del	,	
<u>.</u>	ie deat the att hed for	sicis	in the past 12 mo		4□1	Pregnant at Unknown			Other (sp						Month	Day	Year
P.O.	that the de ed by the detached	Physician/Med	9 Unknown					***					00- Did				da a the?
Ś	es B eg	by	Part II. Other significa			DIJE			naeriying d	ause give	en in Part I.			Yes 2	se contribute to 2 No 3 ☐ Pr		Unknown
ord	w requir been si should	sted	PARKI	مرق وح		2)/3/	1.16										
Record	e taw has b	Completed	DEMI	TAT	P								24a. Was		24b. Were at prior to death?	itopsy findings completion of	cause of
A IE	Th ate pag	S			_								1 □ Yes	25 No	1 Yes	2 No	
Vital	Physicien: The this certificate ral director, pag	Be	25. Was case referred examiner?	/	Hospital:	1		57.6		Othe			(Check only				
of	Phys	T.	1 ☐ Yes 2 ☑ No 27. Manner ol Death	0	1	1 Hipatie Date of Inju		ER/Outpaties 28b. Time o					e 5 ∐ Resi 8d. Describe		Other (Spe	cify)	
	ding h. After fune	tion		5 Pending		Date of Inju (Month, Da	ý Year)	Injury	М	8c. Injury! Work	<br Yes 2 □	No					
Division	Attending in death.	fica	3 Suicide	6 Could no	ot be 28e.	Place of Inj	ury - At ho	me, larm, st	reet, factor	, office		2			d Number or Ru	ıral Route Nur	nber,
ă	al or a after t Dire	Certification:	4  Homicide	-		building, et	с. (Брөсту	"					City or To	wn, State,	)		
	To the Hospital or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral		29a. Certifier 1	Certifying	Physicien: 1	To the best	of my kno	wiedge, deat	h occurred	at the tim	ne, date an	d place, a	nd due to the	cause(s)	and manner as	stated.	
	he Hin 24 he Fu	edicai	one)		and	manner sta	ated.								place, and due		
	To the within 2 To the complet	Σ	29b. Signature and titl	le of certifier		1	7		290	. License	number	~		29d. Dat	e signed (Mont	h, Day, Year)	
,			/ (pt	1to	7/2	Egyl	in	D		02	635	8		APR	116/	0,200	1
	1		30. Name and address	s of person w	no completed	Lause of o	eath (Item	23а) (Туре,	Print)	2 -	***	_	->:				
				Day Year)	+ W	FI C	FZ.	m)		R 1~	, C C=	1-12	2767	( 6 )	e signed (Mont	206	18
	Sta Registi		31. Date filed (Month,	APR	1 1 20	15 Negistr	S Signa	I'M'	los	the)							
	negisti	CII					OT ATTEMPT	7 10	19/10	-							

Physici	an_	1. Decedent's Name (First, Middle, Las	t)				2. Date of Dea Month	ath Day Ye	
/Medic	cal	GLENWOOD BRADFOR			4b. City, Town, or	Langting of D	2.22.2.2.2	13, 2005	12:25
Examir	ier	4a. Facility Name (If not institution, give	Street and number)		MT. LAKI		<del>ga</del> u i	GARR	
uneral		5. Social Security Number 6. Se	W	st birthday)	If Under 1 Year Months Days	If Under 24	Hrs. 8. Date of Birt Min. (Month, Day NOV 4,		Birthplace (State or Fore
rector		230-42-4601	MM 2□F 67	Yrs.	World Days		NOV 4,	1937 V	IRGINIA
A ==		Usual Residence of Decedent  10a. State 10b. County	10c. City,	Town or Lo	cation				10d. Inside City Lim
e-f sh	tor	MD GARRETT		MT. I	AKE PARK				1 <b>K</b> Yes 2 □
or 28	Olrec	10e. Street and Number			10f. Zip Code			10g. Citizen of What	t Country?
a 23a	ral	605 I STREET	12. Was Decedent Ever in U.S.	12.1	21550		(Specify Vec or No	USA	American Indian,
od other then "natural", or itama 23s or 28e-f show event, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status  1 □ Never Married 2 ☒ Married  3 □ Widowed 4 □ Divorced	Armed Forces?  1 X Yes 2 No If Yes, Give Year or Dates: 55-63		f Yes, specify Cuba I ☐ Yes 2█ No	Specify:	? (Specify Yes or No- uerto Rican, etc.)	Black, V	Vhite, etc.
natura Ilcali	Completed	15. Decedent's Ed		16a. Deced	lent's Usual Occupa	ation furing most of	workina	16b. Kind of Busine	ess/Industry
Men "	mple	Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	DO NOT use retired	)		רשדות מפת	TECTIVE SER
other then vent, the Me		17. Father's Name (First, Middle, Last)	4	200	TAL WUKKI		Name (First, Middle,		TECTIVE SEP
o pea	To Be	RALPH MEADE RINAR	D			HELE		ANTMIER	
itam 27 is marked other treumatic ev	۴	19a. Informant's Name/Relationship (7	ype, Print)		•	and Number o	Rural Route Numbe	r, City or Town, Stat	te, Zip Code)
n 27 is er tre		DELORES RINARD -			I STREET	MT.	LAKE PARK	, MD 2155	0
If itam 2 or other		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐	Removal from State cen	netery, cren	sition (Name of natory or other place		Date	20c. Location - City	
rtant:		'4 □Donation 5 □ Other (Specify			IEMORIAL (				MD 21550
Important: If its any injury or of once.		21. Signature of Fund of Service Licen	erst MOO16		Name and Addres  RUST FUNI		P.O. ME - OAKL	BOX 243 AND, MD 2	1550
attending physician and authorise as the burial-transit	lical Examiner	disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Little Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. NON-SMALL CE Due to (or as a conseque  b. Due to (or as a conseque  c. Due to (or as a conseque  d.	ence of):					YEARS
								22d Date of	
uttending or use as	ysiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnand 1 ☐ Live birth 2 ☐ Fetel d 4 ☐ Pregnant at time of dea 9 ☐ Unknown	death 3□	Ectopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year
igned by the attending be detached for use as	by Physiclan/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 ☐ Live birth 2 ☐ Fetel d 4 ☐ Pregnant at time of dea 9 ☐ Unknown	déath 3⊡ ath 5⊡	Other (specify)	en in Part I.		Month	Day Year
ate has been signed by the attending bage 2 should be detached for use as	Physiclan/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live birth 2 ☐ Fetel d 4 ☐ Pregnant at time of dea 9 ☐ Unknown	déath 3⊡ ath 5⊡	Other (specify)	on in Part I.		Month  bbacco use contribut  fes 2 \( \text{No} \) 3 \( \text{ar} \)  an 24b. Were sy prior med?	Day Year  e to the cause of death?  Probably 4 Unknote autopsy findings availate completion of cause n?
ate has been signed by the attending bage 2 should be detached for use as	Be Completed by Physiclan/M	23b. Was decedent pregnant in the past 12 months?  1	1 Live birth 2 Fetel d 4 Pregnant at time of dea 9 Unknown  ontributing to death but not result	Jeath 3 ☐	Other (specify)	26. Place of	1	Month  bbacco use contribut  fes 2 \( \text{No} \) 3 \( \text{Signature} \)  sy prior death  2 \( \text{M} \) No 1 \( \text{No} \)	Day Year  e to the cause of death?  Probably 4 □Unknot  autopsy findings availate completion of cause  7  Yes 2□ No
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After this certificate has been signed by the attending funeral director, page 2 should be detached for use as	To Be Completed by Physiclan/M	23b. Was decedent pregnant in the past 12 months?  1   Yes   2   No   9   Unknown  Part II. Other significant conditions	Hospital: 1 Inpatient 2 Fel Id    1 Live birth 2 Fetel d  4 Pregnant at time of dea  9 Unknown  20 Unknown  1 Inpatient 2 El  28a. Date of Injury  (Month, Day Year)	Jeath 3 that the string in the un	t 3 DOA Other	26. Place of <sup>9⊓</sup> 4 □ Nursir	1 ⅓ Y  24a. Was autop performed to the performance of the performance	Month  bbacco use contribut  'es 2 \( \text{No} \) 3 \( \text{an} \)  an 24b. Were sy prior deat! 2 \( \text{M} \) No 1 \( \text{No} \)  tence 6 \( \text{Other} \) (S	Day Year  e to the cause of death?  Probably 4 □Unknote autopsy findings availate to completion of cause 17?  Yes 2□ No
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irector: After this certificate has been signed by the attending n by the funeral director, page 2 should be detached for use as	Certification; To Be Completed by Physician/M	23b. Was decedent pregnant in the past 12 months?  1	Hospital: 1 Inpatient 2 El  28a. Date of Injury (Month, Day Year)  28e. Place of Injury - At hombuilding, etc. (Specify)  ysicien: To the best of my knowl inner: On the basis of examination	P/Outpatien 28b. Time of Injury	t 3 DOA Other  28c. Injury Work M 1 Does, factory, office	26. Place of  at  at  Yes 2 □ No	24a. Was autop performed to the control of the con	Month  bbacco use contribut  fes 2 No 3   an 24b. Were prior death 2 No 1   lence 6 Other (Street and Number or m, State)  cause(s) and manner	Day Year  e to the cause of death?  Probably 4 Unkno  a autopsy findings availa to completion of cause of the
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			1-	For State Registrar	State of Ma	arytant		artment of r tificate of			leg. No.	
	Physici		1. [	Decedent's Name (First, Middle, Las Elizabeth	() 1.	Scl	hneide	r		2. Date of Dea Month April	Day 2005	3. Time of Death
>	/Medic Examir		4a.	Facility Name (If not institution, give	street and number)			4b. City, Town, o	or Location of Death	1	4c. County of D	eath
				Holy Cross Rehab. &	Nursina Hama	9		Burton	sville		Mont	gomery
	Funeral Director			6. Secorial Security Number 6. Secorial Security Number 6. Secorial Security Number 11	x 7. Ag ☐M 2K☐F	9 (In yrs. la	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day March 2		Birthplace (State or Foreign Country) New York
	p ,			ual Residence of Decedent		10a Cib.	Town or La					10d. Inside City Limits
	ith the Marylan or 28a-f show	~		a. State 10b. County			, Town or Lo					1 ☐ Yes 2 ☑ No
	288-1	Director	_	aryland   Montgon	nery		Silver	Spring 10f. Zip Code			10g. Citizen of What	
	with i	급	106	3701 Internation	al Drive.	Ant.	231		20906		USA	-
	ns 23	Funeral	11.	Marital Status	12. Was Decedent				Hispanic Origin? (S an, Mexican, Puert	pecify Yes or No-		merican Indian,
920	i 72 hours after death with the Maryland "netural", or Items 23a or 28a-f show idical Examination out be notified at	Ď.		1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced	Armed Forces? 1 ☐ Yes 2 ☐ X If Yes, Give Year or Dates:	No		f Yes, specify Cub 1 ☐ Yes 2 ☐xNo		o Hican, etc.)	Specify: V	/hite, etc. Vhite
215-0036		Completed		15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	ucation de <i>completed)</i> College (1-4or 5	i+)	16a. Dece (Give life.	dent's Usual Occup kind of work done DO NOT use retire	oation during most of wor d)	rking	16b. Kind of Busine	ess/Industry
21	filed wil Hygien ther th	Con		12				Housekee				Industry
nd	should be filed within nd Mental Hygiene. marked other than imatic event, the Mental Hygiene.	Be	17.	Father's Name (First, Middle, Last)	1- No				- 10		Maiden Sumame)	
Maryland	2 should b and Menta Is marked raumatic e	ပု		Alexander Patric							Barrett	
Mar	12 sh h and 7 Is m		19	a. Informant's Name/Relationship (7			19b. Mailii	ng Address (Street	ana Number or Hu Ar	ot. 231	r, City or Town, Stat	e, ZIP Code)
	1 and Healt em 2 ther		20:	Bernard J. Moore  a. Method of Disposition	Brotner	20b. PI		Internation (Name of matory or other pla		Date	r Spring, 20c. Location - City	
Baltimore,	permit. Pages 1 and 2 Department of Health a Importent: If item 27 Is any injury or other tra			1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 █ Other (Specify	Removal from State		_	natory or other pla Heaven Cer	P	ril 8,	Solet	
Ħ	artme orten injur			. Signature of Funeral Service Licen				-			Home Inc	ring, Marylan
B	Deparent Dep			AnneMa	richo	Y De,	5 5	rancis J 00 Unive	. Collins csity Blv	Funeral d, W, Si	Home Inc lver Spri	ng,MD 20901
68760,	Physician and Imperior of the principle	edical Examiner	Seif a ca	shock, or heart failure. List only imediate Cause (Final sease or condition sulting in death) squentially list conditions, any, leading to immediate use. Enter Underlying use (Disease or injury at initiated events sulting in death) Last	a. Athero Due to (or as b. Due to (or as c. Due to (or as d.	scler a consequ a consequ	uence of); uence of);					Interval Between Onset and Death
P.O. Box 6	death certi e attending d for use a	Physician/Me		FEMALE: b) Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal	death 3[	∃Ectopic pregnanc ∃ Other <i>(specify)</i> _	у		23d. Date of Month	delivery Day Year
	requires that the een signed by th nould be detache		Pa	nt II. Other significant conditions o Spinal Stenosi						23e. Did to		e to the cause of death?  Probably 4 🖫 Unknown
of Vital Records,	e law has b ye 2 st	Completed by	_	Depression						24a. Was autop	sy prior med? deatl	
tal	icien: Th certificate rector, pag	e C	25	. Was case referred to medical					26. Place of Dea	1 ☐ Yes ath (Check only or	3.	Yes 2 No
>	Physicien: this certific ral director,	To B		examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1   Inpatie	ent 2 🗆	ER/Outpatie	nt 3 DOA Ot	h.o.o.		ence 6 Other (5	Specify)
ion o	fing After fune		27	. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Inju (Month, Da	ry y Year)	28b. Time o Injury	Wo	ry at irk? ] Yes 2 □ No	28d. Describe h	ow injury occurred	
Division	To the Hospital or Attence within 24 hours after death To the Funeral Director: completely filled in by the	Certification:		3 Suicide 6 Could not be determined	28e. Place of Inj building, et	ury - At ho c. <i>(Specif</i> y	me, larm, st	reet, factory, office		28f. Location (S City or Tow	treet and Number of n, State)	r Rural Route Number,
	e Hospita 24 hours e Funere etely fille	edical (	29		ysician: To the best niner: On the basis o and manner st	f examinat						
	within To th compl	Me	29	b. Signature and title of certifier				29c. Licen	se number	- 2	29d. Date signed (M	
	1			If my 6	Bran-	et.	m		Do 818	8	4-7-	2005
	>		30	Name and address of person who Hugo Graziani,					Silver Sp:		20910	
<b>.</b>	St Regist	ate	31	Date filed (Month Day Year)	005 32 legistr		4	celes		<del></del>		

			1 - For Stete Registrar	State of		nd / Depa		t of H	lealth a		lental Hy		9.00		13981
			1. Decedent's Name (First, Middle, La	st)	•						2. Date of De	ath		· · · ·	3. Time of Death
п	Physici /Medic		NATU		SHARIF	F					April	8, <sup>Da</sup>		Year	9:10 ам
	Examin		4a. Facility Name (If not institution, give	e street and numb	er)		4b. City,	Town, or	Location of	f Death		40	. County	of Death	
			Prince Georges H	ospital (	Center		Chev	erly	•			I	Princ	e Ge	orge
	Funeral Director		061-42-9660	Sex 7. DXDXM 2□F	Age (In yrs. 54	last birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min.	8. Date of Bir (Month, Da Dec • 2	th 17. Year 2, 19	50	9. Birthp Coun Bron	lace (State or Foreign try) X, New York
	ryland thow	_	Usual Residence of Decedent  10a. State 10b. County		10c. Cit	y, Town or Lo	ocation						<u>, ,</u>	1	0d. Inside City Limits
	Ba-f s	cto	Va. Loudou	n	S	terlin	g								1 ☐ Yes 2 Ã No
	ith th	Dire	10e. Street and Number				10f. Zip						tizen of W	hat Coun	try?
	ath w	ra	46930 Shady Poin		<del></del>			0164					S.A		
36	parmit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hydione. Important: If time 27 is marked other then "natural", or Itams 23a or 28a-f show eny injury or other treumetic event, If a Medical Examinar must be notified along.	by Fune	11. Marital Status  1 □ Never Married 2 ★ Married  3 □ Widowed 4 □ Divorced	12. Was Decede Armed Force 1 Yes 2 If Yes, Give Year or Date	∍s? ሺ No		Was Deced If Yes, spec 1 ☐ Yes	_		jin? (Spe , Puerto	ecify Yes or No Rican, etc.)	)-		, White,	an Indian, etc. ack
Š	2 hou	ted	15. Decedent's E	ducation		16a. Deced	dent's Usua	I Occupa	ation			16b. K	and of Bu	siness/Inc	dustry
Maryland 21215-0036	within 73 ene. then "na	mple	(Specify only highest gri	College (1-4)	or 5+)	life. I	kind of wor DO NOT us noiss	e retirea	during most I)	of worki	ng		part mple		•
0 0	filled Hygi othar ant,	e Cc	17. Father's Name (First, Middle, Last			COIL	IIOTSS	Eur	18. Mother	r's Name	(First, Middle				
an	lid be lental rkad c	o B	Earl Williams						Mary	Johr	son				
ary	should Nand Nand Nand Nand		19a. Informant's Name/Relationship (	Турө, Print)		19b. Mailir	ng Address	(Street a	and Number	r or Rura	l Route Numb	er, City	or Town, S	State, Zip	Code) 20164
Σ.	and 2 ealth n 27 i		Josephine Sharif	f, Wife					oint		re Apt	.103	,Ste	rling	g,Va.
ore	of He		20a. Method of Disposition  1 Burial 2 Coremation 3 D	Removal from Sta	20b. F	lace of Dispo cemetery, crem	sition (Nan natory or o	ne of ther plac	θ)		ate	20c. L	ocation - (	City or To	wn, State
Ĕ	Pag iment tant:		`4 □Donation 5 □Other (Special	<b>5</b> y)	Cr	emetery, crem tropol emator	y		4	/11/	2005	Alex	andr	ia,Va	а.
Baltimore,	parmit Depart Import eny in		21. Signature of Funeral Service Lice	O A	nus						s Fune ssas,V			, Inc	2.
	Priysician		23a. Part1. Enter the disease, or comshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on eac	h line.	h. Do not ent	W.		- 27		r respiratory a	rrest,			Approximate Interval Between Onset and Death
3	/Medical Examiner			b /	as a conseq	tersn	si.								15 2 ave
	sit ad	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or	as conseq	uence of):									,
	and and I-trans	xam	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or	as a onseq	uence of):	1	Dit s	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	i.e					8 days
8760,	ate be exacuted hysician and the burial-transit	calE		4	40 4 40 11004	231100 0171									V
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.O. Box	that the death cartificate be exacuted nad by the attending physician and detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnan 9 ☐ Unknown	n 2 ∏ Feta tat time of d	Ideath 3	]Ectopic pre ] Othe <i>r (sp</i> e						23d. Date Mon		ry Day Year
<u>С</u>	that t	y Ph	Part II. Dther significant conditions	contributing to deat	h but not res	ulting in the ur	nderlying ca	ause give	en in Part I.		23e. Did t	obacco i	use contri	bute to the	e cause of death?
ords	w requires that been signad I should be det	ted by									10	Yes 2	□ No	Proba	ably 4 Unknown
of Vital Records,	Tha tarate has page 2	Completed									24a. Was autor perio 1 \( \text{Yes} \)	rmed?	pr	or to con	esy findings available inpletion of cause of
<u>                                      </u>	icien: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:				Δ Othe			(Check only o				
on of	ding Physicien: h. After this certifics funeral director, i	tlon: To	1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending 2 Accident investigatio	28a. Date of I (Month,		ER/Outpatien 28b. Time of Injury		Bc. Injury Work	4 🗀 1401.	2	ne 5 🗌 Resident				)
Division	To the Hospital or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certification the funerel director, to the funerel director, and the funeral director, and the funeral director, completely filled in by the funeral director,	Certification:	2 Accident Investigatio 3 Suicide 6 Could not b 4 Homicide determined	e 28e. Place of	Injury - At ho etc. (Specify	ome, farm, stre y)	eet, factory				8f. Location ( City or To			r o <i>r Rur</i> al	Route Number,
	ne Hospiti 24 hours e Funere letely fille	Medical C	29a. Certifier (Check only one)  Certifying Pf 2 Medical Example 1	nysician: To the be niner: On the basi and manner	s of examina	wledge, death tion and/or inv	occurred a vestigation,	at the tim	e, date and pinion, death	place, a	and due to the ad at the time,	cause(s) date and	and man	ner as stand due to	ated. the cause(s)
•	withir To th comp	Me	29b. Signature and title of certifier	use 1	1 · D.				number 584	88			te signed		
-	3		20 Name and address of person who	completed cause of	of death (Item	23a) (Type,	Print)								
	Sta Registr		Meyada ISSa, S  31. Date filed (Month, Day, Year)  APR 11 2	32 Reg	istrar's Signa	ture	we .								

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. C 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** Per Jason 2005 1111 -ru/na OV /Medical 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner mont Kensi cronshi 137 Omere Date of Birth (Month, Day, Yea Dec. 22, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) if Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Davs Min. Year) Months 87 Hours 1⊠ M 2□ F 537-16-4237 Director 1917 Montana Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other treumatic event, the Medical Examinar must be notified at 10d. Inside City Limits 1 ☐ Yes 2 K No Director Kensington Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2919 Burtonhill Drive 20895 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, atc. permit. Pages 1 and 2 should be filed within 72 hours atter Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or ite morphily or other treumatic event, the Medical Examina any lipury or other treumatic event, the Medical Examina once. 1 ☐ Yes 2 ⊠ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 Tes 2 No Specify: Specify: White <u>≽</u> 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Applied Physics Elementary/Secondary (0-12) College (1-4or 5+) 4 Laboratory Electrical Engineer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Jason Shepperd Frieda Ljunggren ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John W. Shepperd/ Son 1716 N. Greenbrier Street, Arlington, VA 22205 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State April 8 2005 Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, Virginia Francis J. Collins Funeral Home Inc 21. Signature of Funeral Service Licensee 500 University Blvd, W, Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of): Physician/Medical Examiner attending physician and for use as the burlel-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off. Division of Vital Records, P.O. Box 68760 Due to (or as a consequence of): Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably M Unknown Completed by 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed? certificate has 1 ☐ Yes 1 TYes 2 TNo To the Hospital or Attending Physicisn: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To Yes 2□No 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) Director: After the in by the funera 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 2 Accident 5 Pending investigation r death. 1 Yes 2 No 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide efter within 24 hours e
To the Funerel C
completely filled 1 Certifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

29c. License number

2101

DME

MP DOME

100042

Silver

29d. Date signed (Month, Day, Year)

090DL

State

29b.

Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Registrar

Physicia /Medic Examine		1. Decedent's Name (First, Middle, Last	")				g. No. UUU	1 0 2 0 0
		Emma Swayne  4a. Facility Name (If not institution, give 11301 Penny Av			4b. City, Town, or Location o		Day Year 5 / 2005 4c. County of Death	3. Time of Death 10:35a
Funeral Director		Social Security Number 6. S		n yrs. last birthday, 77 Yrs.	Clinton  If Under 1 Year   If Under 2  Months   Days   Hours	24 Hrs. 8. Date of Birth (Month, Day, 1 1 1 / 27 /	Prine Ge  Year)  9 Birthpla Country Peter	orge ce (State or Foreig Ssburg, '
neturel', or Items 23e or 28e-f show Jisal Exar in et trust ke nedified at	Director	10a. State 10b. County P . G .	10	c. City, Town or L Clin			100	d. Inside City Limit:
23e or 2	al Dire	10e. Street and Number 11301 Penny A	ve		10f. Zip Code 20735	10	g. Citizen of What Country USA	y?
el', or Items Ever-inet l'e	by Funeral	11. Marital Status  1 Never Married 2 Married  3XX Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Was Decedent of Hispanic Orig If Yes, specify Cuban, Mexican, 1 ☐ Yes 2 ★ No Specify:	gin? (Specify Yes or No- , Puerto Rican, etc.)	14. Race - Americar Black, White, et Specify: Blac	c.
then "	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12) 12th	cation de completed) College (1-4or 5+)		dent's Usual Occupation kind of work done during most DO NOT use retired)  are Giver	of working	6b. Kind of Business/Indu	stry
othe	To Be C	17. Father's Name (First, Middle, Last) Peter Paul Gi			18. Mother	r's Name (First, Middle, Ma nma Jane Sc	aiden Surname) ott	
n 27 is m er treum	Ŋ	19a. Informant's Name/Relationship (T) Karen Bush-Mul	ling Daugh	nter 1	ng Address (Street and Number 1301 Penny A			ode)
Department of Health and Menta Importent: If item 27 is marked any injury or other treumatic events.		20a. Method of Disposition  1 □ Spurial 2 □ Cremation 3 □ I  4 □ Donation 5 □ Other (Specify,	)	Harmon	y Memoriar	4/12/05	Landover,	1d
Depar Impor any in once.		21. Signature of Funeral Service Licens	800	2	Snead funer 5732 Georgi	al Home & a Ave NW W	Cremation ashington,	Servio DC
ıysicia ne bur	ical Ex	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, isading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	a. PARKINS Due to (or as a co b. ARTIN Due to (or as a co Due to (or as a co d	ensequence of): Sclentic sclentic	sevel Homet oise	ne	C	onset and Death
led by the attending phi detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknowrt	23c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3[	□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Da	ay Year
igne be d	by	Part II. Other significant conditions co	ntributing to death but no	ot resulting in the u	nderlying cause given in Part I,	23e. Did toba 1 ☐ Yes	cco use contribute to the	cause of death?
e has	Completed					24a. Was an autopsy performe	24b. Were autops prior to comp death? No 1 \( \square\) Yes 2(	letion of cause o
this o	ation: To Be	25. Was case referred to medical examiner?  1  Yes  2 No  27. Manner of Death  1 Natural  5  Pending 2  Accident investigation	Hospital: 1 Inpatient 28a. Date of Injury (Month, Day Yea	2 ER/Outpatier  28b. Time o Injury	nt 3 DOA Other: 4 Nur	of Death (Check only one) sing Home 5 N Resident 28d. Describe how	ce 6 □Other (Specify)	
thours after death  Funeral Director: tely filled in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - building, etc. (S	pecify)		City or Town, :		
	edical	29a. Certifier 1 Certifying Phy 2 Medical Exami	sician: To the best of my ner: On the basis of exa and manner stated.	y knowledge, deat imination and/or in	h occurred at the time, date and vestigation, in my opinion, death	I place, and due to the cause h occurred at the time, date	se(s) and manner as state e and place, and due to th	ed. e cause(s)
C # C	Σ	29b. Signature and title of continue  White Carrie			29c. License number D3 5206 Print) Wingsh Road	290	I. Date signed (Month, Da	y, Year)

DHMH 17 Rev 1/2001

			-	State of Maryla	and / Depa		lealth and N	Mental Hyg	•	ne.	1000
>	.Physici /Medio	cal	Decedent's Name (First, Middle, Last)  Jei	come A. Sve	С	4h City Town	a Landina of Conth	2. Date of Deat Month April	Day 9 20	)05	3. Time of Death 4:55 A M
	Examir Funeral	ner	4a. Facility Name (If not institution, give str  Howard County General  5. Social Security Number  6. Sex	ral Hospita	rs. last birthday)	Colum	r Location of Death  bia  If Under 24 Hrs.  Hours Min.	8. Date of Birth (Month, Day,	4c. County of Howa	ard	ce (State or Foreign
1.	Director works Japan	or	Usual Residence of Decedent  10a. State 10b. County	10c.	Yrs.	ocation		Sept 18	3,1922	Mary	7land I. Inside City Limits 1 ☐ Yes 🌠 No
20	be filed within 72 hours after death with the Maryland tal Hygiene.  do other than "natural", or items 23a or 28a-1 show event, its Medical Evaria er must be troillied at	by Funeral Director	10e. Street and Number 10522 Vista Road	. Was Decedent Ever in Armed Forces? 1 XYes 2 No If Yes 6 ye		10f. Zip Code 21044	dispanic Origin? (Span, Mexican, Puerto			Stat - American , White, etc	CES Indian,
0000-01717	l within 72 hour iene. iene. r then "natural" ir e Medical Ev	Completed b	15. Decedent's Educa (Specify only highest grade of Elementary/Secondary (0-12)	Year or Dates: 194: tion completed) College (1-4or 5+) 5+	16a. Dece (Give life.	dent's Usual Occup kind of work done DO NOT use retired		ung	16b. Kind of Bus	Whit iness/Indus	
ır yldınu 4	2 should be filed withir and Mental Hygiene. Is marked other than aumatic event, It a Mi	To Be C	17. Father's Name (First, Middle, Last)  John C. Svec  19a. Informant's Name/Relationship (Type						Maiden Surname		ode)
Dalilliore, Mo	i. Pages 1 and 2 rtment of Health a rtant: If item 27 li njury or other tra		Donna Tugwell/Daugh  20a. Method of Disposition  1 № Burial 2 □ Cremation 3 □ Rer  4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licensee	noval from State Co	Place of Dispo cometery, cres olumbia	osition (Name of matory or other place Memorial	Pk 4-14	Date 2	20c. Location - C Clarksv	ille,	
,00V	Pnysician /Medical Examiner	Ilcal Examiner	23a. Part1. Enter the disease, or complica shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  d. d.	tions that caused the decause on each line.  Large Bowe  Due to (or as a cons  Due to (or as a cons  Due to (or as a cons	42. A path. Do not enter a pat	112 Old C	olumbia F	ike Elli	cott Ci	ty, M	D 21043  pproximate iterval Between inset and Death hours
O. BOX 00	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physiclan/Medl	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	. If yes, outcome of preg 1 Live birth 2 Fe 4 Pregnant at time o 9 Unknown	etal death 3	Ectopic pregnancy	,		23d. Date Mont	of delivery h Da	
Colus, T	v requires that been signed b should be deta	by	Part II. Other significant conditions contributions  Dementia	buting to death but not r	esulting in the u	nderlying cause giv	en in Part I.			Probab	ly 4 Unknown
אוומו חפו	ician: The lav ertificate has ector, page 2	Be Completed	25. Was case referred to medical examiner?	anitali.				autopsy perform  1 Yes 2	y pri ned? de ∰ No 1 [		y findings available letion of cause of
IN ISIOII OI	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	ertification; To	1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined	pital: Inpatient 2 28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At building, etc. (Spe	28b. Time of Injury	f 28c. Injur Wor M 1 🗆	y at	ome 5 ☐ Reside 28d. Describe ho 28f. Location (Str City or Town	w injury occurred	d	Route Number,
_	ne Hospital n 24 hours a ne Funeral I	edical Ce	29a. Certifier (Check only one)  29a. Medical Examine	ian: To the best of my k r: On the basis of exami and manner stated.	nowledge, death	h occurred at the tir vestigation, in my o	ne, date and place, pinion, death occur	and due to the ca red at the time, da	use(s) and mani ite and place, an	ner as state nd due to th	ed. e cause(s)
	To the within To the Comp	M	29b. Signature and title of Sertifier  30. Name and address of person who com		em 23a) (Type	29c. Licens D348			Apr 9,		y, Year)
7	Sta	ate	Steve Diener, MD 1 31. Date filed (Month, Day, Year)	1055 Little 32. Registrar's Sig	Patuxe		ay Columb	ia, MD 2	1044		
	Registr	rar	APR 1 2 20	05 Resur	A St.	Joseph 5					

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Day Year **Physician** JAMES OSCAR STAUB SR April 8, 2005 2:15 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Frederick Memorial Hospital Frederick Frederick If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 AM 2 ☐ F Hours Yrs. Director 212**-**38**-**8684 Sept. 15,1941 Maryland Usual Residence of Decedent 10a. State 10b, County 10c. City, Town or Location 10d. Inside City Limits Pages 1 and 2 should be filled within 72 hours after death with the Marylan nent of Health and Mental Hygiens.

The fill ferm 27 is marked other than "natural", or Items 23e or 28e-1 shown it Item 27 is marked other than "natural", or Items 23e or 28e-1 shown into or other traumatic event, Item Maritaal Examples or other examples or other ex Director 1 ☐ Yes 2√2 No Maryland Frederick Woodsboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11627 Creagerstown Road 21798 Funerai USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2(TXNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: þ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 6 Heavy Equipment Operator Lime Quarry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Nelson Staub 0 Catherine Ridenour 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 ia
any injury or other trau Mary Staub/Wife 11627 Creagerstown Rd. Woodsboro, MD 21798 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 🔀 Burial 2 □ Cremation 3 □ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) Blue Ridge Cemetery 4/12/2005 Thurmont, MD 21. Signature of Funeral Service Mce 22. Name and Address of Facility Stauffer Funeral Home, PA 104 E. Main Street Thurmont, MD 21788 23a. Part 1. Enterting disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Obstructive Pulminary Chronic 10 years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

physician and s the burial-transit The law requires that the death certificate be executed Box 68760, attending pl P.O. Division of Vital Records, Hospitel or Attending Physicien: Certification; within 24 hours after death.

To the Funeral Director: A completely filled in by the fu Medical

the Maryland

Baltimore, Maryland 21215-0036

Be Completed ို

examiner' 1 ☐ Yes 2 No 27. Manner of Death 1 Natural

2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

5 Pending investigation 6 Could not be determined

Hospital: 1 Inpatient 2 Fr/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year)

28b. Time of

28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

🗏 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

Lerner

29c. License number D0041619 29d. Date signed (Month, Day, Year) April 8, 2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Michale Lerner 31. Date filed (Month APR P 1 2 2005 State

strar's Signature

63 Thomas Johnson Dr. Frederick, MD 21702

Registrar

			For State	State of	Marylan	•	artment <i>tificate</i>			ind M	lental Hy		7 14 15	рчка	1 25 05	0.0
			Registrar  1. Decedent's Name (First, Middle.	Last		Cei	uncate	OIL	eaui	- 1	2. Date of De	Reg. No	4	3	3. Time of D	13 G
	Physici /Medic		Norman Robert	Sullivar	1						April		005	Year	1:00	
	Examin		4a. Facility Name (If not institution, St. Mary's Hosp:	give street and num Ltal	ber)				Location $\alpha$ r $ ext{dtow}$				County of		S	
	Funeral Director		5. Social Security Number 577–48–7568	6. Sex 7 1 M 2 ☐ F	7. Age (In yrs. 68	last birthday) Yrs.	If Under	1 Year Days	If Under 2 Hours	Min.	8. Date of Bir (Month, Da Sept.	th 16 I	936	9. Birthp Cour Was	elece (State or i	Foreign
	ъ		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	y, Town or Lo	cation							1	0d. Inside City	Limits
	Maryla -f eho	tor		fary's		olton'									1 □ Yes 2	
	ith the	Olrec	10e. Street and Number				10f. Zip (		26			10g. Ci	tizen of W	hat Cour	ntry?	
	s 23e	ra	38451 Bayview H			0 140		2062		:-0./0-			USA	A		
396	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. 'Cimpertent: If item 27 is marked other than "neturel" or Items 23e or 28a-f ehow myn njury or other treumatic event, the Medical Exercit art most be indiffical at ance.	by Funeral Director	11. Marital Status  1 Never Married 2 Marrie  3 Widowed 4 Divorced	12. Was Deced Armed Fore 1 Pes, Give Year or Da	ces? 2 🔲 No	,	f Yes, speci	ify Cuban	Specify:	gin? (Spe , Puerto	ecify Yes or No Rican, etc.)	)-		c, White,	an Indian, etc. hite	
2-0	72 hou	eted	15. Decedent' (Specify only highes.			16a. Dece	tent's Usual kind of world DO NOT use	l Occupat	tion uring most	of worki	ing	16b. K	and of Bu	siness/Ind	dustry	-
21215-0036	within ene. then "	Completed	Elementary/Secondary (0-12)	College (1-	4or 5+)	Distr						Te	leco <sub>1</sub>	muni	cations	3
	be filed tal Hygie d other event, the	Be C	17. Father's Name (First, Middle, L	,							(First, Middle		Sumame	э)		
Maryland	should that marked umatic e	L <sub>o</sub>	Perry H. Sulliv			19h Mailir	na Address	(Street at			Sulliv		or Town	State 7in	Codel	
Ma	and 2 s salth an n 27 is i		Kim A. Whitlock				_				f, Md.			siaro, Lip	0000)	
ē,	other		20a. Method of Disposition	<u> </u>	20b. P	Place of Dispo	sition (Nam	e of			Date			City or To	wn, State	
imo	Pages ment of I ent: If ite ury or of		1 ☐ Burial 2 ☐ Cremation  4 ☐ Donation 5 ☐ Other (Sp							4/1	0/2005	Cha	rlot	te Ha	all, Md	۱.
Baltimore,	permit. Departr Importe any nji		21. Signature of Funeral Service L	9 kul	M0094	5 B:		ield-	-Echo	ls F	uneral		•	2060	2	
	Pnysician		23a. Part1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final	complications that ca only one cause on ea	used the deat	h. Do not ent	er the mode	of dying	such as	cardiac o	1	trese,	Ma.	2062	Approximate Interval Betwee Onset and De	
	/Medical		disease or condition resulting in death)	aDue to (d	or as a conseq	uenga of):	100	Ort	100	(1-5	ection	1			<u> </u>	
	Examiner	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (c	or as a conseq	uence of)	hyl	nm	4					- Y	MINH	PC
,0928	cate be executed physician and the burial-transit	dical Exa	resulting in death) Last	Due to (d	or as a conseq	uence of):										
9	entificating phone as the	Med	IF FEMALE:											-		
О. Вох	The law requires that the death certificate has been signed by the attending I age 2 should be detached for use as	Physiclan/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		rth 2 ☐ Feta ant at time of d	Ideath 3□	Ectopic pre Other (spe						23d. Date Mon		ry Day Ye	ar
rds, P.	quires that n signed b uld be deta	by	Part II. Other significant conditio	ns contributing to de	ath but not res		nderlying ca	_	n in Part I.			tobacco i Yes 2	_		ne cause of dea ably 4 □Un	
Records,	sicien: The law requir certificate has been si irector, page 2 should I	Completed	1								24a. Was auto perfo		pi de	/ere autorior to coreath?	psy findings av πpletion of cau	/ailable use of
Vital		Be C	25. Was case referred to medical examiner?			,			26. Place	of Death	(Check only o					
of V	this ald	မ	1 ☐ Yes 2 No			ER/Outpatier			4 🗌 INUI		me 5 ☐ Resi				()	
on	ng After	tlon	27. Manner of Death  Natural 5 Pending  Accident investig	,	n, Day Year)	28b. Time of Injury	M	3c. Injury Work? 1   Y	at ? ′es 2.⊟N		28d. Describe	now inju	ry occurre	90		
Division	al or Atter s after dea I Director d in by the	Certification;	3 Suicide 6 Could r 4 Homicide determi	ned Zoe. Flace	of Injury - At ho	ome, farm, str	eet, factory,	, office			28f. Location ( City or To			er or Rura	l Route Numbe	Θ <i>r</i> ,
	To the Hospitel or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fi	Medical C		Physiolen To the examiner: On the ba and mann	sis of examina											
	To the within 2 To the comple	Σ	29b. Signature and title of certifier	De-	1	1 .	29c.	License		7		29d. Da	te signed	(Month,	Day, Year)	
•			- When	- 4 ~		TWO T	Dei-th	Dog	5388	1	1.	11/2	mil	8.	2005	
P	BIN	1	30. Name and address of person or lee Panitch					Roa	d I a a	mará	ltown,	Мант	land	206	50	
	Sta		21 Date filed (Month Day Year)	2 2005 32. Re	gistrar's Signa	ature	berli	Noal	ч тео	marc	LEVWIL	uary	Tand	ZUD.	<i>J</i> V	
	Regist	rar	,			-										

Norman Robert Sullivan

			1 - For State Registrar	State of N	Marylan		artment tificate			ind M	ental Hy	giene		. 130	100
	Physici	an	1. Decedent's Name (First, Middle, L	ast)							2. Date of D Month	Day			
1	/Medic Examin		Marie F. Staub  4a. Facility Name (If not institution, gr	ve street and numbe	r)		4b. Citv.	Town, or	Location o		April		005 County of D	10:29	P <sup>M</sup>
1	Examin	eı	13013 View Point		,		Bowie							Georges	
	Funeral		,	Sex 7. A		ast birthday)	If Under Months	1 Year Days	If Under 2 Hours	Min.	8. Date of Bi (Month, D	rth ay, Year)	9. E	Birthplace (State of Country)	or Foreign
	Director		578-46-3078 Usual Residence of Decedent	1 L M 2 L M	6	8 Yrs.			j	1	May 22	, 193	36 Wa:	shington	
	ylend		10a. State 10b. County	<u></u>	10c. City	, Town or Lo	cation							10d. Inside C	ity Limits
	e Mar	ctor	Maryland Prince	Georges	Bowi	.e								1 X Yes	2 🗌 No
	vith th	Director	10e. Street and Number	_			10f. Zip						zen of What	Country?	
	eeth v	erai	13013 View Point	Lane 12. Was Deceder	nt Ever in U.S	S 13 V		715	spanic Oric	nin? (Sper	cify Yes or N	USA	14. Bace - A	merican Indian,	
ထ	after d	Funerai	1 Never Married 2 Married	Armed Forces	s?		f Yes, spec	ify Cubar	n, Mexican	, Puerto F	Rican, etc.)		Black, W		
ğ	ural', c	þ	3 XWidowed 4 ☐ Divorced	If Yes, Give Year or Dates	s:		1 🗌 Yes 2		Specify:				Specify: W	hite	
<u>7</u>	n 72 h	Completed	15. Decedent's (Specify only highest g	Education rade completed)		16a, Deced (Give	ient's Usua kind of wor DO NOT us	k done di	urina most	of workin	g	16b. Ki	nd of Busine	ss/Industry	
212	iene r than	ошо	Elementary/Secondary (0-12)	College (1-4o	r 5+)	Homen		, , , , , , ,				Owr	1 Home		
힏	al Hyg	Be C	17. Father's Name (First, Middle, Las	t)					18. Mothe	r's Name	(First, Middle				
yla	ould b	2	Unknown						Eva :						
Maryland 21215-0036	d 2 sh th and 7 is m treum		19a. Informant's Name/Relationship Paul W. Staub/ S								Route Numb				
	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylend Department of Health and Mental Hygiene. Importent: if item 27 is marked other than "natural", or iteme 23e or 28e-f show any injury or other treumatic event, the Medical Examinar must be notified at an once.		20a. Method of Disposition	OII	20b. PI	lace of Dispo	sition (Nam	ne of			ate	_		or Town, State	
Ë	Pages sent or int: if i		1 🌠 Burial 2 □ Cremation 3 `4 □ Donation 5 □ Other (Spec		Θ	red He	-			4/12/	/2005	Bowi	le, MD		
Baltimore,	permit. Departri importe any inju		21. Signature of Funeral Service Lice	ensee			The state of the s							eral Hom	e
Ш	20.5 2 3		23a. Part1. Enter the disease, or con								1 Bowi		2071	5 Approximat	
8760,	Physician /Medical Examiner puisician upon tension and puisician upon tension the provided tension of	icai Examiner	shock, or heart failure. List only immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Atherose Due to (or a Due to (or a Due to (or a	clerol us a consequ Diabe us a consequ nsion us a consequ	uence of): etes Me uence of):			lar D	iseas	se			Interval Bet Onset and	Death
.O. Box 6	ath certifi ittending or use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcom 1 □ Live birth 4 □ Pregnant 9 □ Unknown	2 ☐ Fetal at time of de	death 3□	Ectopic pre					2	23d. Date of o	,	Year
ds, P	luires that the de n signed by the a lid be detached f	þ	Part II. Other significant conditions	contributing to death	but not resu	ulting in the un	nderlying ca	ause give	n in Part I.		1			to the cause of c	
al Records,	icien: The law require certificate has been si ector, page 2 should b	Completed									24a. Was auto perfe 1 Yes	psy ormed?	24b. Were prior t death 1 🗌 Y	autopsy findings to completion of c ? es 2 \( \text{No} \)	available ause of
Vital	Physicien: r this certific ral director,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital: 1 ☐ Inpa	tiont 2 🗆 s	ER/Outpatien	t 3 DO	Othor	~		(Check only		2 000 10	(6.)	
Division of	ding Afte fune	ation; To	27. Manner of Death  1 XNatural 5 ☐ Pending 2 ☐ Accident investigati	28a. Date of In (Month, E		28b. Time of Injury		Bc. Injury Work	4 LI IAUI	28	e 5X Res 8d. Describe			pecify)	
Divis	or Life	Certification;	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	4   200. Flace of I	njury - At ho etc. <i>(Specify</i>	me, farm, stre	eet, factory	, office		21	8f. Location ( City or To	Street and wn, State)	d Number or )	Rural Route Num	ber,
	To the Hospitel or within 24 hours after To the Funerel Direction completely filled in I	Medical (	29a. Certifier 1 Certifying F (Check only one) 1 Medical Example 1	hysician: To the besiminer: On the basis and manner	of examinat	wledge, death ion and/or inv	occurred a vestigation,	at the time in my opi	e, date and inion, deat	d place, ar h occurre	nd due to the d at the time,	cause(s) date and	and manner place, and d	as stated. lue to the cause(s	i)
	To the within To the comp	ğ	29b. Signature and title of certifier					License				29d. Date	e signed (Mo	onth, Day, Year)	
				1				DOC	26	382		Apri	1 7, 2	2005	
				completed cause of			,		<b>a</b> . t	10-		_		D 00=15	
	Sta	te	Marc R. Shepar	32. R	trar's Signat	ure			Suite	e 105	Colle	ege P	ark, N	עט 20740	
	Registr		APR 0 7	2005	due.	A A	boul	9							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) APRIL 5,2005 Year 3:05 P M **Physician** ROBERT SMALL STAILEY /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Anne Arundel Arnold 1217 Brunswick Ct. If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** 1X M 2 F Illinois 9-17-1924 Director 356–16–1150 80 Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10a. State 10b. County ral, or items 23e or 28e-f show Examiner must be notified at 1 Yes 2X No Anne Arundel Arnold Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21012 USA 1217 Brunswick Ct. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: 1943 -46 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Specify: White þ 3 ☐ Widowed 4 ☐ Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry I've Medical 15. Decedent's Education (Specify only highest grade completed) Internal Revenue nartment of Health and Mental Hygiene ortent: If item 27 Is marked other then Injury or other traumatic event, If a Mis Elementary/Secondary (0-12) College (1-4or 5+) Service Branch Chief 3 yrs. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Ina Small Enoch George Stailey 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1217 Brunswick Ct., Arnold, MD 21012 Judith F. Stailey/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【\*Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Importent: If any Injury or once. 4-7-05 Edgewater, MD Kalas Crematory 21. Signature of Film / Service Licensee 22. Name and Address of Facility GEORGE P.KALAS FUNERAL HOME 2973 SOLOMONS ISLAND ROAD, EDGEWATER, MD. 21037 · CKC Approximate Interval Between Theet and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 0 Priysician mossa /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) Box 68760, attending physician for use as the IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 4☐Pregnant at time of death P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Be Completed by funeral director, page 2 should be 3 Probably 4 Unknown 1 Yes 2 □ No 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2,2 No 2 No 1 Yes 1 Yes Division of Vital 25. Was case referred to medical examiner? 26. Place of Death Check on one Other: Hospital: 1 Yes 2 No 4 Nursing Home 5 Residence 6 □Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of De th After 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No М 24 hours after death. Funerel Director: A 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined filled in by 4 - Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier within 24 29d, Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 2 completed cause of death (Item 23a) (Type, Print) 30. Name and address of per 31. Date filed (Month, Day, istrar's Signature State APR 0 Registrar

			1 - For State Registrar	State of Maryla		epartment of F			ene	10000
	Physici /Medio Examir	al	1. Decedent's Name (First, Middle, Last FYQNCiS  4a. Facility Name (If not institution, give	JOhn street and number);	50	Derlein 4b. City, Town, o	or Location of Death	2. Date of Death Month	Day Year 11 200 5	
	Funeral Director		5. Social Security Number 6. Se 219–12–4250	Jeeks Hi M 20 F 84	Me s. last birth	day) If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, Yo	Garre 9. Birth Co 1921 Mary	hplace (State or Foreign untry)
	the Maryland 28a-f show	Director	Usual Residence of Decedent  10a. State 10b. County  MD Garrett  10e. Street and Number		cider			100	. Citizen of What Co	10d. Inside City Limits 1 X Yes 2 □ No
<b>J36</b>	filed within 72 hours after death with the Maryland Hygiene. vther than "natural", or Items 23a or 28a-f show ant, the Medical Examiner must be notified at	by Funeral DI	214 South Main Str 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 M Yes 2 M No If Yes, Give Year or Dates: 1942		21520  13. Was Decedent of Hif Yes, specify Cuba	dispanic Origin? (Spe an, Mexican, Puerto Specify:		USA  14. Race - American Black, White Specify:	ncan Indian, a, etc.
121215-0036	led within 72 hou lygiene. her than "nature it, the Medical E	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation	16a. D	ecedent's Usual Occup Give kind of work done ife. DO NOT use retired	during most of worki	A A	o. Kind of Business/I	•
Maryland	d 2 should be fi th and Mental H 7 is marked otl traumatic ever	To Be	17. Father's Name (First, Middle, Last) Franklin Earl Spoe 19a. Informant's Name/Relationship (T) Olive Spoerlein/Wi	pe, Print)		Mailing Address (Street	Emma I. S	l Route Number, C	ity or Town, State, Z	ip Code)
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be nutilized at once.		20a. Method of Disposition  1 © Burial 2 Cremation 3 F  4 Donation 5 Other (Specify)  21. Signature of Funeral Service License	lemoval from State	Place of D cemetery,	box 244, isposition (Name of crematory or other place metery  22. Name and Address 179 Mill P.O. Box 2	April ss of Facility Ne	14,2005 ewman Fund	Accident Eral Homes	, Maryland
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complishock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	cations that caused the detection on each line.  Stage  Due to Tras a const	Z n	t enter the mode of dyin	g, such as cardiac o	r respiratory arrest,		Approximate Interval Between Onset and Death Mun Hus
,760,		Ical Examiner	Sequentially list conditions, it day, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	Due to (or as a conse					V	
.O. Box 68	ath certific	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of preg 1 □ Live birth 2 □ Fe 4 □ Pregnant at time of 9 □ Unknown	tal death	3 □Ectopic pregnancy 5 □ Other (specify)			23d. Date of delive Month	very Day Year
Records, P.	w requires that the de been signed by the a should be detached f	by	Part II. Other significant conditions con	ntributing to death but not re	esulting in th	ne underlying cause give	en in Part I.	23e. Did tobacc	co use contribute to 2 □ No 3 Pro	
	ysician: The law is certificate has b director, page 2 st	Be Completed	25. Was case referred to medical				26. Place of Death	24a. Was an autopsy performed 1 Yes 2	prior to co death?	opsy findings available ompletion of cause of
Division of Vital	ttending Physicii death. tor: After this cer the funeral direci	P	27. Manner of Death  1 Natural 5 Pending	lospital: 1 Inpatient 2 [ 28a. Date of Injury (Month, Day Year)	ER/Outpa 28b. Tim Inju	ne of 28c. Injury	er: ursing Hon vat 2 k?		e 6 □Other (Speci njury occurred	( <b>ý</b> )
Divisio	al or Attendii s after death. N Director: A sd in by the fu	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spec	home, farm		Yes 2 □No	8f. Location (Street City or Town, St	and Number or Rur ate)	al Route Number,
	To the Hospital or Attenwithin 24 hours after deatl To the Funeral Director: completely filled in by the	Medical (	29a. Certifier (Check only one)  Certifying Physical Medicel Exemination (Check only one)	sicien: To the best of my kr ner: On the basis of examin and manner stated.	nowledge, on ation and/o	leath occurred at the time investigation, in my op	pinion, death occurre	ed at the time, date	and place, and due t	to the cause(s)
1	DEVA PERS	_	30. Name and address of person who co	mpleted cause of death (Ite		D 000	12575	9 AI	Date signed (Month,	2005
	Sta		31. Date filed (Month Pay Year) 4	Mann,	MD,	PO Boj	×247 e	Acciden	+ MD	21520
	Registr	ar	1 1 1 2 4	State .	B	Amosth 1				

ician dical		. Decedent's Name (First, Middle, La	ast)		ertificate of	Dealii	2 Date of Death		3. Time of Death
uicai,	_	Howard E. Sm	ith				AMonth .	Day	245 p
niner	4	a. Facility Name (If not institution, gi			4b. City, Town, o	r Location of Death	7	4c. County o	of Death
	_	Washington Count	y Hospital			erstown		Wash	ington
al or			Sex 7. Age (	'In yrs. last birthday 83 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, ) May 14,	Year) 1921	Birthplace (State or Foreig Country)     Maryland
	-	10a. State 10b. County	1	IOc. City, Town or I	Location				10d. Inside City Limit
햦	2	Md. Washi	ngton	Sm	ithsburg				1 ☐ Yes 2 🛣 N
Funerai Director	1	0e. Street and Number			10f. Zip Code		100	g. Citizen of Wi	hat Country?
rai C	3	12508 Bradbury	Ave.		21	783			U.S.A
nuel	1	1. Marital Status	12. Was Decedent Event Armed Forces?		. Was Decedent of H tf Yes, specify Cuba	lispanic Origin? (Spean, Mexican, Puerto	ecify Yes or No- Rican, etc.)		- American Indian, , White, etc.
þ	5	1 Never Married 2X Married 3 Widowed 4 Divorced	1 ☑ Yes 2 □ No If Yes, Give Year or Dates:	11 10	1 ☐ Yes 2 🔀 No	Specify:		Specity:	White
ete	-	15. Decedent's E (Specify only highest gi		(Giv	edent's Usual Occup re kind of work done DO NOT use retired	durina most of worki	ing 16	6b. Kind of Bus	siness/Industry
Completed		Elementary/Secondary (0-12)	College (1-4or 5+)		Drive	*		Truck	Co
Be C	1	17. Father's Name (First, Middle, Las	it)			18. Mother's Name	e (First, Middle, Ma		
ToB	3	Silas M. Smith				Minnie	M. Wolfe	3	
		19a. Informant's Name/Relationship	(Type, Print)	19b. Mai	ling Address (Street				Nate, Zip Code)
	Ш	Ruth V. Smith (W:	ife)	1250	8 Bradbur	v Ave. Sm	ithsburg.	Md. 21	783
1	2	20a. Method of Disposition	Domesti from Chate	20b. Place of Disp	oosition (Name of ematory or other place		Date 20		City or Town, State
		1		Ringgold	Cemetery	20	1 11, 05	Ringgo	ld.Md.
once.		21. Signature of Funeral Service Lice	Mo Mo	1414	22. Name and Addre				bury Ave.
a		e le le	e Davis	ş J	.L. Davis	Funeral I	Home Smit	hsburg	,Md. 21783
<	1	23a. Part1. Exter the disease, or con	mplications that caused the y one cause on each line.	e death. Do not e	nter the mode of dyin	ng, such as cardiac o	or respiratory arres	st,	Approximate Interval Between
ın		Immediate Cause (Final disease or condition	Cong	portivo	lacalle	20:00	262		Onset and Death
al- er		resulting in death)		PEC 13	reach	- Jack Cary	t .		Mouth
		4	Due to (or as	onsequence of):	near	Jailey	•		Monthy
			b		near	percus	e		Months
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o Be Completed by Physician/Medical Examiner		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown	b. Due to (or as a condition of the cond	consequence of):  consequence of):  pregnancy  Fetal death 3 ne of death 5  not resulting in the	□Ectopic pregnancy □ Other (specify) _ underlying cause giv	en in Part I.  26. Place of Death	23e. Did toba  1  Yes  24a. Was an autopsy performe 1 Yes 2 Conference on the conference of the conference of the conference of the conference on the conference on the conference of the confer	Mont  2 1 0 3  24b. Wy pride de 1 1	of delivery th Day Year  Dute to the cause of death?  B Probably 4 Unknow  ere autopsy findings available for to completion of cause of auth?  Yes 2 No
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Certification: To Be Completed by Physician/Medical Examiner		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown  Part II. Other significant conditions  25. Was case referred to medical examiner? 1   Yes 2   No 27. Manner of Death   Natural   Significant   Natural   Significant   Significan	b. Due to (or as a contribution of the best of and manner state)  Due to (or as a contribution of the best of and manner state)  Due to (or as a contribution of the best of the best of the best of and manner state)	pregnancy   Fetal death 3 me of death 5 mot resulting in the 2 EP/Outpatitive and 28b. Time Injury (- At home, farm, s (Specify) my knowledge, deaxamination and/or id.	DEctopic pregnancy Other (specify) underlying cause giv  ant 3 DOA of 28c. Injur Wor M 1 Doa street, factory, office ath occurred at the tir nvestigation, in my o	en in Part I.  26. Place of Deather: 4 \( \) Nursing Horyat  X? Yes 2 \( \) No  ne, date and place, a pinion, death occurred in the number 2 1457	23e. Did toba  1 Yes  24a. Was an autopsy performe 1 Yes 2 En (Check only one) me 5 Residence 28d. Describe how  28f. Location (Stre-City or Town, and due to the cau ed at the time, date  290  L	Mont  2 Mo 3  24b. We pring de 1 Ce 6 Other rinjury occurred set and Number State)  set and place, and place, and Date signed of 1 Ce 2 Ce 3 Ce 3 Ce 3 Ce 3 Ce 3 Ce 3 Ce 3	of delivery th Day Year  oute to the cause of death? B Probably 4 Unknow ere autopsy findings availablor to completion of cause of eath? Yes 2 No  or (Specify) d  or or Rural Route Number, the cause (s) (Month, Day, Year)

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registre Certificate of Death Reg. No. 3. Time of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** Ralph Louis Sharrett APRIL /Medical 102005 12:50 A 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner RAVENWOOD LUTHERAN VILLAGE HAGERSTOWN
If Under 1 Year If Under 24 Hrs. WASHINGTON 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**∑**M 2□F Months Days Hours Min 94 Director Virginia June 15, 1910 219-12-0512 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Washington <u>Hagerstown</u> 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? ō 20009 Rose Bank Way Items 23a 21742 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after ☐ Yes 2 No f Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 X No Specify: Completed by Specify: White 3 X Widowed 4 ☐ Divorced Year or Dates: "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene important: If tiem 27 la marked other than any rigury or other traumatic event, tra Magnes. Elementary/Secondary (0-12) College (1-4or 5+) 12 President/Owner Automotive 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be William Delaney Sharrett Mary Elizabeth Miller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sally Perryman/Daughter 13320 Clopper Road, Hagerstown, MD 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 □ Cremation 3 □ Removal from State ` 4 ☐ Donation 5 ☐ Other (Specify) Rose Hill Cemetery 4/13/05 Hagerstown, MD 22. Name and Address of Facility Gerald N. Minnich Funeral Home 21. Signature of Funeral Service Licensee Dy 305 N. Potomac St., Hagerstown, MD 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician a Alber osceration Carolio vasalen deseare 2 weeks /Medical Due to (or as a consequence of) **Examiner** aspiration 1 Month euwery Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ue to (or as a consequence Examiner physician and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) detached 9☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 QUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has irmed? 20**€** No 1 Tes Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 1 ☐ Yes 2 ☑ No Division of this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After or Attending Injury 1 Natural 1 ☐ Yes 2 ☐ No death 2 Accident investigation 24 hours after death Funeral Director: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 4-11-85 1) 28365 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

14-12

MANZAR

SHAPI.

32. Registrar's Signature

SHARRETT, Louis Ralph

Some D. Sperke

368 mill stred - Hagustonn MD 21740

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 2005 LAGRETTA 520 AM 04 /Medical 4a. Facility Name (If not institution, give street and number) 4b. Cily, Town, or Location of Death 4c. County of Death Examiner WASHINGTON WASHINGTON COUNTY HOSPITAL HAGERSTOWN If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) DEC. 28, 1 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛛 F 220-18-0572 Director 86 1918 MARYLAND Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a, State 10b. County 10c. City, Town or Location itam 27 is marked other than "natural", or Itams 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at 10d. Inside City Limits 1 X Yes 2 □ No Director MARYLAND WASHINGTON BOONSBORO 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21713 141 SOUTH MAIN STREET U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Be Completed by If Yes, Give Year or Dates: Specify. 3 Widowed 4 □ Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry i and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 8 NURSES AIDE NURSING HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be finent of Health and Mental I CHARLES EDWARD BOWERS MARY CATHERINE METZ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GLENN A. MALOTT/ADMINISTRATOR 9428 DOWNSVILLE PIKE, WILLIAMSPORT, MARYLAND 21795 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State ō permit. Pagé Department d Important: If any injury or once. \*4 □Donation 5 □ Other (Specify) SALEM LUTHERAN CEM. 4/14/2005 BAKERSVILLE, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 7606 Old National Pike BAST FUNERAL HOME ∠Paul M. Dean Boonsboro, Maryland 23a. Parl 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Munonea disease or condition resulting in death) 2 well. /Medical Due to (or as a consequence of): Examiner Schan omste Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner The law requires that the death certificate be executed use as the burial-transit attending physician and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 KNo Year Month Day 4□Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Debiletalun 4 Unknown 1 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 2 No 1 Yes or Attanding Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 2 Other 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No М 2 Accident filled in by the t Director: 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To tha Funaral I 12 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1)4656 Order 04.11.05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KADIN 20311 LO AD SOMIBORO MA LAPP MY HMMA 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

			For Stete Registrar	State of	Maryland / Do		tment of He		d Mental H	lygien Reg. N	A 4	nas a
	Physici /Medic		1. Decedent's Name (First, Middle, Lass Helen Catherine S	hubert					2. Date of Month		2001	3. Time of Death A
	Examin	er	4a. Facility Name (If not institution, give Washington County				4b. City, Town, or I Hagerst		eath	4	c. Cdunty of Dea Washing	
	Funeral Director		Social Security Number 6. S		. Age (In yrs. last birth		If Under 1 Year Months Days	If Under 24		Day, Year	9. Bir	thplace (State or Foreign puntry)
	aryland show	٦.	Usual Residence of Decedent  10a. State 10b. County  MD Washing	ton	10c. City, Town							10d. Inside City Limits 1 ⊋Yes 2 □ No
	with the M 3a or 28a-f	Funeral Director	MD Washing  10e. Street and Number  11 S. Walnut St.,		Hager .4B	SLO	10f. Zip Code 21740			10g. C	itizen of What Co	
980	d within 72 hours after death with the Maryland jiene. r than "natural", or Items 23a or 28a-f show the Madical Examirar must be multified at	þ	11. Marital Status  1 Never Married 2 Married 3 Wildowed 4 Divorced	12. Was Deced Armed Ford 1 Tes 2 If Yes, Give Year or Dat	Z/No	If Y	as Decedent of His es, specify Cuban	spanic Origin n, Mexican, P Specify:	? (Specify Yes or uerto Rican, etc.)	No-	14. Race - Ame Black, Whit	
21215-0036	d within giene. ir than	Completed	15. Decedent's Ec (Specify only highest gra	lucation de completed) College (1-		(Give kii life. DC	nt's Usual Occupa nd of work done di NOT use retired) USEKEEPE	uring most of	working		Kind of Business Housekee	
Maryland	s 1 and 2 should be filed f Health and Mental Hygi itam 27 is marked othar other traumatic avant,	To Be C	17. Father's Name (First, Middle, Last) Adam Stansbury Ne						Name (First, Midd na Blanch			-
Mari	d 2 sho		19a. Informant's Name/Relationship (*)  Judy Ann Hall / D	•			Address (Street a					
	0 0	1	20a. Method of Disposition		20b. Place of D		izabeth ion (Name of tory or other place		Date	-	Location - City or	
Baltimore,	permit. Pages Department of Important: If it any injury or o		1 XBurial 2 Cremation 3 4 Donation 5 Other (Specification 21. Signature of Funeral Service Lice	)	Leiter	22.1		s of Facility	Gerald N	. Miı	nnich Fu	meral Home MD 21740
	Pnysician /Medical Examiner		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on ea	used the death. Do no ch line.	enter					,	Approximate Interval Between Onset and Death
68760,	icate be executed physician and sthe burial-transit	edical Examiner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	r as a consequence of	atre	Lac Failu	lure re	Nor			
.O. Box 68	ath certif attending for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	1☐Live bir	ome of pregnancy th 2 ☐ Fetal death nt at time of death wn		ctopic pregnancy Other (specify)				23d. Date of de Month	livery Day Year
<u>α</u>	w requires that the de been signed by the s should be detached t	by	Par II. Other significant conditions of	ontributing to dea	ath but not resulting in t	the und	erlying cause give	n in Part I.				o the cause of death?
Vital Records,		Completed							24a. W au pe 1 🗆 Yes	topsy rformed?,	prior to death?	utopsy findings available completion of cause of
Viita	stcian: certific rector,	o Be (	25. Was case referred to medical examiner?	Hospital:	2 TERIO :		Other	-	Death (Check on			
o			1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of (Month	patient 2 EP/Outp Injury 28b. Tir , Day Year) Inj		28c. Injury Work	4 🗀 IVUISII	ng Home 5 Re 28d. Describ	_		cify)
Division	tha Hospitel or Attanding hin 24 hours after death. tha Funaral Diractor: Atten mpletely filled in by the fune	Certification:	3 Suicide 6 Could not be determined	288. Place 0	of Injury - At home, farm g, etc. (Specify)	m, stree	t, factory, office			n (Street a Town, Stat		ural Route Number,
	To the Hospitel or A within 24 hours after To the Funeral Direct completely filled in b	Medical (	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exer	ysician: To the t ninar: On the bas and manne	pest of my knowledge, sis of examination and/ er stated.	death o	stigation, in my op	e, date and p inion, death	lace, and due to to occurred at the tim	ne cause(s	s) and manner as nd place, and due	s stated. to the cause(s)
)	To t To t	W	29b. Signature and title of certifier  +	mulu	\		29c. License	0 3 9	6	29d. D.	ate signed (Mont	h. Day, Year)
15	H-2		30. Name and address of person who	completed cause	of death (Item 23a) (T	Type, Pr	(1)	Han	and	21	747	
Ī	Sta Regist		31. Date filed (Month) Day (Year)	2005 32. R	gistrar's Signature	Pop	ents	1100	, , , , ,		, ,	

Please Type or Print in Black Indelible Ink.	Ensure All Copies Are Legible.
State of Maryland / Department of H	ealth and Mental Hygiene

			1 - For State Registrar	State of Ma	ryland /		artment of H tificate of L		Mental Hy	gier Reg. N	Ph. do	
	0		Decedent's Name (First, Middle, Last)						2. Date of De	eath	4000	3. Time of Death
	Physicia /Medic		Gladys Henrietta	SWORD					APRIL	14,	2005	6:50 A M
	Examin		4a. Facility Name (If not institution, give				4b. City, Town, or		th		4c. County of Death	
			RAVENWOOD LUTHERA  5. Social Security Number 6. Sec		(In yrs. last b	irth day)	HAGERST	OWN If Under 24 Hr	S 0 Date of Bi		WASHINGT(	
	Funeral Director				36	Yrs.	Months Days	Hours Mir		lo, i	1918 We	nplace (State or Foreign untry) st Virginia
	yland now		10a. State 10b. County		10c. City, To	wn or Lo	cation	,				10d. Inside City Limits
	a-1sh	ctor	Maryland Washin	gton		Hag	gerstown					1 ☐ Yes 2X No
	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or Items 23a or 28a-1 show or other traumatic event, the Marylad Expli	Funeral Director	10e. Street and Number Walnut Point Road				10f. Zip Code	1740		10g. (	Citizen of What Co	untry?
<b>'</b> 0	fter deal r Items	Funer	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 🐴 N		1	Was Decedent of Hi f Yes, specify Cuba		Specify Yes or Note Rican, etc.)	0-	14. Race - Amer Black, White	
03	ral', o	by	3 AWidowed 4 □ Divorced	If Yes, Give Year or Dates:			1 ☐ Yes 2 ☒ No				Specify: wh	ite
5-0	"natu	ietec	15. Decedent's Edu (Specify only highest grad	cation e completed)	16	a. Deced	dent's Usual Occupa kind of work done o DO NOT use retired	ation during most of we	orking	16b.	Kind of Business/I	ndustry
21215-0036	iene. than	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)	##O. L	manage				tavern	
	be filed tal Hygis d other event,	Be C	17. Father's Name (First, Middle, Last)						me (First, Middle		len Sumame)	
yla	should be ind Mental s marked o umatic eve	70	George Kyne						s Michae			
Maryland	d 2 sho th and 7 Is mu trauma		19a. Informant's Name/Relationship (Ty  James M. Sword - se		19		-			-	y o <i>r Town, St</i> ate, Z Md. 21742	
	Heall tem 2 tem 2		20a. Method of Disposition	JII	20b. Place		sition (Name of natory or other place		Date		Location - City or 1	
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any njury or other tra once.		1 🔀 Burial 2 ☐ Cremation 3 ☐ F  ` 4 ☐ Donation 5 ☐ Other (Specify)		1	-	wn Mem.Pa		3/05	На	gerstown,	Maryland
alti	permit. Departminitimportal any nju		21. Signature of Funeral Service Licens	00	(	22	. Name and Addres	s of Facility	MINNICH	FUN:	ERAL HOME	E
	205 29		- COU	1/////////	WHA)	4.	15 E. Wil	son Blv	l., Hage	rst	own, Md.	
	255 106		23a. Part1. Enter the disease, or compl shock, or heart failure. List only o Immediate Cause (Final	ne cause on each in	e.	o not enti	A A A A A	g, such as cardia	ic or respiratory a	arrest,		Approximate Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death)	Due to (or as a	consequence	e of).	vuvi.					yeas.
	Examiner		Convention list conditions	Hym	erle	en	Son	/				Year
	po iis	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		consequenc	e of):	141	77				10.0011
	xecute and	Examiner	that initiated events resulting in death) Last	Du to (or as a	Consequence	e of):		/ =	_			mosnus
68760,	ificate be execu g physician and as the burial-trai	edicai E		Litte	rle	1 &	Seme	uli	£			Year
	rtificat ng phy s as th		IF FEMALE:									
.O. Box	that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	by Physician/N	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown	3c. If yes, outcome 1□Live birth 4□Pregnant at 9□Unknown	2 Fetal dea		Ectopic pregnancy Other (specify)				23d. Date of deli Month	very Day Year
Δ.	requires that the een signed by th nould be detache	y Ph	Part II. Other signifi ant onditions co	ntributing to death bu	it not resulting	in the ur	nderlying cause givi	en in Part I.	23e. Did	tobacc	o use contribute to	the cause of death?
rds	w requires that been signed b should be deta	ed b	nevi	OF V	-5				1 🗆	Yes	2 2 No 3 □ Pro	obably 4 Unknown
Records,	aw 1s b	Completed	Sep 3	· · · · · · · · · · · · · · · · · · ·					24a. Was auto perf 1 ☐ Yes		death?	topsy findings available completion of cause of
Vital	ystcian: The t is certificate ha director, page	Be C	25. Was case referred to medical examiner?						eath (Check only			
of V	Physician: this certific ral director,	ုင	1 ☐ Yes 2 ☐ No	1	nt 2 ER/C			4 Priursing	-		6 ☐Other (Spec	ufy)
on o	ding F h. After funera	tion:	27. Manner of Death  1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injur (Month, Day	Year) 280	. Time of Injury	Worl	/at (? Yes 2 ∐No	28d. Describe	now in	jury occurred	
Division of	Attending ir death. ector: Alter by the fune	Certification:	3 Suicide 6 Could not be determined	28e. Place of Inju	iry - At home,	farm, str			28f. Location	(Street	and Number or Ru	ral Route Number,
ō	tal or	Cert		1		_						
	To the Hospital or Attending Phywithin 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral.	Medical	29a. Certifier (Check only one)	sician: To the best oner: On the basis of and manner sta	examination a	ge, death and/or inv	n occurred at the time vestigation, in my of	ne, date and place pinion, death occ	e, and due to the curred at the time	cause date a	e(s) and manner as and place, and due	stated. to the cause(s)
	To the To the Comp	Ž	29b. Signature and title of certifier		L	2	29c. License	number		29d. [	Date signed (Month	, Day, Year)
•			wide			)	245	1001	/	The	su 14 2	2000
051	4-3		30. Name and address of person who co	ompleted cause of de	eath (Item 23a	Type,	Print)	M1) 19	110 Post	5000	outhDr	HafMD
:	Sta Regista		31. Date filed (Month, Day, Year) APR 15 20	32. Registra	r's Signature	15/10	arded					151142

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

	Pleas	se Type or I	Print in	Black in	delible Ink	Fnsu	re Al	l Conies	Δre	l egi	ble		
For					artment of F			-		_	Dic.		
- State Registrar				Cei	rtificate of	Death			Reg. No	2.00	15	12	000
1. Decedent's Name	(First, Middle	, Last)						2. Date of De Month	ath Da	······································	Year	3. Tin	ne of Death
		ng Stewar						APRIL		200		9:	30 P M
		give street and nun		0.	4b. City, Town, o		f Death				of Death		
Seriin Nu i. Social Security Nu		& Rehabil			Berl If Under 1 Year	If Under 2	24 Hre	0 D-1 ( D)-		Word	este		
087-14-27	66	6. Sex 1 ☐ M 2 <b>X</b> F	83	last birthday) Yrs.	Months Days	Hours	Min.	8. Date of Bir 03/15/1		)	9. Birthp Cour	ntrv)	ate or Foreign NY
Jsual Residence of I	10b. County		10c. C	ty, Town or Lo	ocation						1	0d. Insid	le City Limits
MD	Word	ester	0	cean C	City								es 2 □ No
304 8th S					10f. Zip Code 2184	2				tizen of \	What Cour	ntry?	
1. Marital Status		12. Was Dece	dent Ever in U	J.S. 13.1	Was Decedent of H	lispanic Orig	gin? (Spe	ecify Yes or No	-	14. Rac	e - Americ		n,
1 ☐ Never Marrie		Armed For ed 1 Tyes If Yes, Giv Year or Da	<b>₹X</b> (10	1	If Yes, specify Cuba 1 ☐ Yes 2 <b>X</b> No	an, Mexican, Specify:	, Puerto	Rican, etc.)			ck, White, /: <b>Whi</b> t		
(Sagai	15. Decedent	's Education t grade completed)		16a. Dece	dent's Usual Occup	pation	of works		16b. F	(ind of B	usiness/Ind	dustry	
Elementary/Secon		College (1	-4or 5+)	life.	DO NOT use retired istrative	d) -		-	C		nmen		
12	44:-44:- 1			Adiiiii	istrative							· L	
7. Father's Name (F		-				_		(First, Middle,					
19a. Informant's Nar		<b>-</b>		19h Mailie	ng Address (Street							Cadal	
George C					C Street							0000)	
1 X Burial 2 C 4 Donation 3	5 ☐ Other (Sp		State	lington 22	National National Name and Addre  8. Name and Millian	Cem	Bu	rbage	5 A Fun	rling eral	Hom	VA	
23a. Part1. Enter the shock, or heard Immediate Cause (Fidisease or condition resulting in death)	inal	commications that ca only one caus on a a.	aysed he dea ach line.	th. Do not ent	er the mode of dyin	ng, such as o	cardiac c	or respiratory ar	rest,				imate Between and Death
Sequentially list con- cause. Enter Underl Cause (Disease or in	ditions, nediale	b. Due to (	or as a honsa	quenne of):									
Dause (Disease or in hat initiated events resulting in death) La		c. Due to (i	or as a consec	quence of):									
IF FEMALE: 23b. Was decedent in the past 12 n 1  Yes 2 9  Unknown	nonths?		rth 2 ☐ Feta ant at time of c	al death 3	Ectopic pregnancy Other (specify)	/				23d. Dai Mo	e of delive	ry Day	Year
Part II. Other signific	cant condition	ns contributing to de	ath but not res	sulting in the u	nderlying cause giv	en in Part I.		23e. Did to	obacco 'es 2		ribute to th		of death?
								24a. Was autop perfo 1 \( \text{Yes} \)	an	24b. \	leath?		ngs available of cause of
25. Was case referre examiner?	ed to medical	Harrie'			172	- 40	of Death	(Check only o	ne)				
1 ☐ Yes 2 ⊋	io		_	ER/Outpatien		d Lines		ne 5□Resid				1)	
27. Manner of Death Natural Accident	5 Pending		f Injury h, Day Year)	28b. Time of Injury	Wor	yat k? Yes 2 □ N		28d. Describe h	iow inju	ry occurr	ed		
3 Suicide	6 Could n determi		of Injury - At h	ome, farm, str	eet, factory, office			28f. Location (S City or Tow	Street ar	nd Numb	er or Aura	l Route I	Vumber.

Examiner the attending physician and thed for use as the burial-transit Division of Vital Records, P.O. Box 68760, cate has been signed by the page 2 should be detached certificate

Pnysician /Medical

> Examiner Be Completed by Physician/Medical Medical Certification: To

To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director; After this certific completely filled in by the funeral director,

Part II. Other s 25. Was case examiner? 27. Manner of

1 - For State Registrar 1. Decedent's

29a. Certifier (Check only one)

To Be Completed by Funeral Director

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

State Registrar

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Mogth, Day, Year)

who completed cause of death (Item 23a) (Type, Print)



		1. Decedent's Name (First, Middle, Las	#26 per doc 4/				2. Date of D	Reg. No eath Da		3. Time of Death
Physician /Medical		Jean Ann	Thompson				April	9, 2	005	3:35 P
Examiner	ľ	4a. Facility Name (If not institution, give				m, or Location of Dea	ith	40	Chanle	
		Civista Medical Ce		last birthday)	If Under 1 Ye	a Plata ear   If Under 24 Hr	s. 8. Date of B	irth	Charle 9. Bir	
Funeral Director		219-48-0763	□ M 2X F 55	Yrs.	Months Da	ays Hours Mir	8. Date of B (Month, D OCt. 3	1, 1	949 Was	thplece (State or Fore punity) hington DC
× ==		Usual Residence of Decedent  10a. State 10b. County	10c. Ci	ty, Town or Lo	cation	<del></del>				10d. Inside City Limi
Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or Items 23s or 28s-1 show any Injury or other traumatic event, the Medical Examiner must be notified at once.  To Re Commissed by Funeral Director	5	Maryland Charles	ς	Walde	orf					1 □ Yes 2 1 N
ygione.  Net than "natural", or Items 23s or 28s-1 e  It, the Maxical Exponent man be notified  Commissed by Enneral Director	3	10e. Street and Number	9		10f. Zip Coo			10g. Ci	itizen of What Co	ountry?
s 23a	1 2	2096 Chapelside (	T	6 42 1	Was Danadast	2060			US 14. Race - Ame	rican Indian
ritem		11. Marital Status  1 □ Never Married 2 Married	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☐ No			of Hispanic Origin? ( Cuban, Mexican, Pue	rto Rican, etc.)	0-	Black, Whit	e, etc.
Entro	Š I	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 □ Yes 💥 □	No Specify:			Specify:	White
"natural		15. Decedent's Ed (Specify only highest gra		(Give	dent's Usual Oc kind of work do DO NOT use re	one during most of w	orking	16b. F	Kind of Business	/industry
tte M	2	Elementary/Secondary (0-12)	College (1-4or 5+)		Secreta			NA	SA	
event,	2	17. Father's Name (First, Middle, Last)					me (First, Middle			
atic e	0	Wilbur A. Boteler					n Ronald			
traum		19a. Informant's Name/Relationship (		1		reet and Number or F side Court				Zip Code)
other		George M. Thompson 20a. Method of Disposition	20b. I	Place of Dispo	sition (Name o	of colored	Date		ocation - City or	Town, Stete
rry or		1 X Burial 2 ☐ Cremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Specify	Inemoval from State			etery 4-1	5-05	Clin	ton, MD	
Importa eny Inju	Ī	21. Signature of Funeral Service Licer	M00053	22 Hi	Name and Ad	neral Home x 156, Wa	2			
= 6 d	1	23a. Part . Enter the disease, or com	valiantians that sourced the dear	P. Do not ont	O. Bo	x 156, Wa	dorf, M	D_20	604	Approximate
3		shock, or heart failure. List only Immediate Cause (Final	one cause on each line.			PUCTIVE			BRY	Interval Between Onset and Death
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iner		Sequentially list conditions.	b			DIS	GASG			
Sit	lie	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consec	quence of):						
rial-transit	ZXal	that initiated events resulting in death) Last	CDue to (or as a consec	quence of):						
o pr	200	(	d							
	2		23c. If yes, outcome of pregn	2001						
Medi	Š	IF FEMALE:			Ectopic pregna				23d. Date of de Month	Day Year
use as i	Clanyme	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 ☐ Feta 4 ☐ Pregnant at time of c		Other (specify	V)				
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Director: After this certificate has been signed by the attending prin by the funeral director, page 2 should be detached for use as traiting that the formal attendance in the Commission of th	to be completed by	23b. Was decedent pregnant in the past 12 months?  1	4 □ Pregnant at time of of Unknown  contributing to death but not res  VG EST/VE  Hospital: 1 ☑ Inpatient 2 □  28a. Date of Injury (Month, Day Year)	sulting in the un  HENOutpatien  28b. Time of Injury  ome, farm, str	Other (specify) Indertying cause  Other (specify) Indertying cause  Other (specify) Index (spe	26. Place of Do Other: 4   Nursing	24a. Wa autur pur pur pur pur pur pur pur pur pur p	yes 2 s an oppsy ormed? 2 No one) how inju	24b. Were as prior to death?  1 Yes  6 Other (Spe	robably 4 Unknow utopsy findings availab completion of cause of 2 No
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Director: After this certificate has been signed by the attending print by the funeral director, page 2 should be detached for use as I have also as the control of the con	edical Certification; 10 be Completed by	23b. Was decedent pregnant in the past 12 months?  1   Yes 2   No 9   Unknown  Part II. Other significant conditions of the conditions of	4 □ Pregnant at time of of 9 □ Unknown  contributing to death but not respond to the second of the second to the second of the	BER/Outpatien  28b. Time of Injury  ome, farm, str	other (specify)  nderlying cause  other (specify)  and a substitution of the substitut	26. Place of Dr. Other: 4 Nursing Injury at Work? 1 Yes 2 No fice the time, date and place my opinion, death occurse number	24a. Wa auture per 1 Yes eath /Check only 28d. Describe 28f. Location City or To be, and due to the curred at the time	s an oppy one) and on	24b. Were at prior to death?  1	robably 4 Unknow utopsy findings availab completion of cause of 2 No  cify)  ural Route Number, s stated. to the cause(s)  h, Day, Year)
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Please Type or Print in Black Indelible Ink.	Ensure All Copies Are Legible.
State of Maryland / Department of H	lealth and Mental Hygiene
Cartificate of I	Dooth

r.		For State Registrar	State of Mar	ryland /		artment of tificate of			giene Reg. No.2 0 0 5	14000	
Dhuaiaia	70	nagistiai						2. Date of De. Month		3. Time of Death	
Physicia /Medic	al .	Charles Earl Trai				4b City Town	or Location of Death	APRIL	8, 2005 4c. County of Dea		
Examine	er	4a. Facility Name (If not institution, giv VA MARYLAND HE		e syst	PEM	PERRY			CECIL		
Funeral Director		5. Social Security Number 6. S		(In yrs. last b		If Under 1 Year Months Days	r If Under 24 Hrs.	8. Date of Bird (Month, Da Feb. 1	th 9. Bir	thplace (State or Foreign buntry) .O	
and and	ctor	Usual Residence of Decedent  10a. State 10b. County		10c. City, To	wn or Lo	cation				10d. Inside City Limits	
Mary me-f sho		Maryland Cecil		North	Eas	t				Y Yes 2 No	
or 284	Funeral Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?									
sath w	eral	105 West High Str	eet 12. Was Decedent Ev	ver in U.S.	13. \	21901 Was Decedent of	Hispanic Origin? (Sp	ecify Yes or No	United Stat		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23c or 28a-f show important: If item 27 is marked other than "natural", or items 23c or 28a-f show any injury or other traumatic event, the Medical Example Incilling at 200c.	by Fun	1 Never Married 2 Married  3 Widowed 4 Divorced	Armed Forces?  1 XYes 2 No If Yes, Give Year or Dates:		1	f Yes, specify Cu 1 ☐ Yes 2 No	ban, Mexican, Puerto	o Rican, etc.)	Black, Whi	te, etc. vhite	
72 hou	eted	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working							/Industry		
within ane. than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+			DO NOT use retir	•		U.S. Air H	orce	
il Hygid other ent, L	a)							ne (First, Middle	(First, Middle, Maiden Sumame)		
Menta Menta arked atic ev	To B	Grover White  Ruth Trainor  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 19b. Mailing Address)									
12 sho h and 7 is mu traum		19a. Informant's Name/Relationship		1							
Healt Healt tem 2		Waunita Harvey/Daughter 105 West High Street, North East, Maryland 21901  20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State									
Pages nent of int: If it		XXBurial 2 Cremation 3 Removal from State  NXBurial 2 Cremation 3 Removal from State  Delaware Veterans  April 13,  Memorial Cemetery  2005  Bear, Delaware									
permit. Departmimporta mporta any inju		21. Signatur Funeral Service Licensee 22. Name and Address of Facility Crouch Funeral Home									
₫O E ai oi	8 8	127 South Main Street, North East, Maryland 21901  23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest,  Approximate physical Behveson									
Dhysisian	_	chook or heart failure. List only one cause on each line								Onset and Death	
Physician /Medical										UNKNOWN	
Examiner		Sequentially list conditions.	b. Due to (or as a	consequent	ce of):			<del></del>			
neit	Examiner	cause. Enter Underlying Cause (Disease or injury									
te be executed ysician and te burial-transit	Exal	that initiated events c									
ate be thysiciathe the bu	dical										
Attending Physician: The law requires that the death certificate r death. r death. ector: After this certificate has been signed by the attending phys by the funerat director, page 2 should be detached for use as the	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of	2 Fetal dea		□Ectopic pregnar	ncy		23d. Date of de Month	olivery Day Year	
res that the de signed by the a be detached t	nysic	1   Yes 2   No 9   Unknown 4   Pregnant at time of death 5   Other (specify)   9   Unknown									
s that gned b	by PI	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23e. Did tobacco use contribute to the cause of death?  1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown		
w require been signature								-		,	
has b	Completed							24a. Was auto perfe	nsv prior to	completion of cause of	
iician: Th certificate rector, pag	e Co	25. Was case referred to medical 26. Place of Death (Check only one)								s 2 No	
lysicie lis cert direct	To B	examiner? 1   Yes 2 X No									
ling Pt I. After th uneral	ion:	27. Manner of Death  1 ZNatural 5 Pending (Month, Day Year)  1 Natural 5 Pending (Month, Day Year)  M M 28b. Time of Injury at Work?  1 Yes 2 No									
or Attend fler death Director: ,	Certification:	2 Accident 3 Suicide 4 Homicide  investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location City or To	8f. Location (Street and Number or Rural Route Number, City or Town, State)		
To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	ledical Ce	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
To the within To the comple	Med	29b. Signature and title of conflier	1-11	29c. License number					29d. Date signed (Mor	nth, Day, Year)	
->-0		Mark Albert in 020390						APRIL 8, 2005			
++IVA		30. Name and address of person who					1- 0	7			
1 . 1 4 . 1		Charles Hoesch		Mary ar's Signature		d Healt	n Care S	ystem,	rerry Po:	INT, MD	

Registrar